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Community Impact Analysis of the Proposed Conversion of CareFirst, Inc. to a For-Profit Business Entity and the Merger Between CareFirst, Inc. and WellPoint Health Networks Inc.

January 2002

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January 10, 2002

William L. Jews
President and Chief Executive Officer
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117

Dear Mr. Jews:

You have requested that Accenture prepare a Community Impact Analysis report (hereinafter, the "Report") for CareFirst BlueCross BlueShield ("CareFirst").

The objective of our Report will be to help you to assess the probable effects of CareFirst's conversion to a for-profit business entity and merger with WellPoint Health Networks Inc., upon the availability, accessibility, and affordability of health care for the citizens of Maryland, Delaware and Washington, D.C. We have conducted this analysis at CareFirst's request. We understand that CareFirst, should it choose to do so, will submit the Report to the State of Maryland as part of an application under Section 6.5-201 of the State Government Article, Annotated Code of Maryland to seek approval for the proposed conversion and merger, and may choose to submit this report to Delaware and Washington, D.C. as part of its filings to those jurisdictions as well. The analysis covers only part of what CareFirst is required to submit in order to gain approval and we have assumed that materials to address the remaining requirements of applicable laws and regulations will supplement it.

This report has been prepared for the specific objective described above and is intended for no other purpose.

Please feel free to contact us regarding any follow-up required to this Report.

Best regards,

Joe Marabito
Partner
Accenture

Community Impact Analysis

Covering CareFirst BlueCross BlueShield's Conversion to a For-Profit Business Entity and Merger with WellPoint Health Networks Inc.

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I. Purpose of the Community Impact Analysis

The purpose of this section is to state the objective of this report, to present definitions of relevant terms, and to state Accenture's relationships with the parties involved in the proposed transaction.

Accenture was retained by CareFirst to prepare a Community Impact Analysis report (hereinafter, the "Report") for CareFirst and its non-profit operating subsidiaries (collectively, "CareFirst"). The objective of the Report is to determine the probable impact upon the availability, accessibility and affordability of health care in the primary communities served by CareFirst of a conversion of CareFirst from a non-profit business entity to a for-profit business entity and a merger with WellPoint Health Networks Inc. (hereinafter, "WellPoint").

For the purposes of this Report, the primary communities served by CareFirst are taken to be the populations of the states of Maryland and Delaware and Washington, D.C. The impacts we describe in this Report primarily affect CareFirst members, since this population most directly interacts with CareFirst. The impacts we describe in this Report secondarily affect the communities in which CareFirst operates because there may be changes to the health system resulting from CareFirst's proposed conversion and merger.

For the purposes of this Report, we use the following definitions of availability, accessibility and affordability:

- Availability: "The relationship of volume and type of existing services and resources to a person's volume and type of need." (see Penchansky and Thomas, "The Concept of Access – Definition and Relationship to Consumer Satisfaction" in Medical Care, XIX(2), 127 – 140)

- Accessibility: "The ability of a population or a segment of the population to obtain health services. This ability is determined by economic, temporal, locational, architectural, cultural, organizational and informational factors which may be barriers or facilitators to obtaining services." (Bureau of Health Planning, p.54 as cited in Khan and Bhardwaj, 1994, p. 63). For the purposes of this analysis, we focus on the economic, organizational and informational factors influencing accessibility, as they apply to the role of a health plan in conducting its business. The other factors influencing accessibility, including the temporal, locational, architectural and cultural factors, are more directly influenced by other participants in the delivery of health care (e.g., doctors, hospitals, home health care suppliers, etc.) and less likely to be influenced by a health plan.

- Affordability: "The relationship of the price of services to people's ability to pay for the services." (see Penchansky and Thomas, "The Concept of Access – Definition and Relationship to Consumer Satisfaction" in Medical Care, XIX(2), 127 – 140)

It should be noted that Accenture also provides services to WellPoint. These services are not related to the proposed merger with CareFirst, and the team of Accenture personnel involved in preparing this Report is entirely separate from the team providing services to WellPoint. Neither Accenture nor any Accenture Partners involved in preparing this Report currently hold directly or indirectly (other than through the holding of mutual funds) or plan to acquire the stock of WellPoint during the timeframe of this transaction. While Accenture will receive a pre-arranged fee from CareFirst for the preparation of this

Report, the amount of the fee does not depend upon the approval or disapproval of the proposed transaction by the respective jurisdictions.

Accenture has previously worked with CareFirst to help CareFirst better understand trends within the health care industry and explore strategic options within the context of those trends. The most recent work Accenture has completed for CareFirst in this area was documented in the paper titled "An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response", published in November of 2001 and excerpted here in this Report, in the section titled Health Care Industry Context. "An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response" was produced prior to the announcement of CareFirst's intent to convert to for-profit status and merge with WellPoint.

We understand that CareFirst may choose to submit this Report to: (i) the Insurance Commissioner of the State of Maryland as part of an application under Section 6.5-201 of the State Government Article, Annotated Code of Maryland; (ii) the Insurance Commissioner and Corporation Counsel of Washington, D.C.; and (iii) the Insurance Commissioner and Attorney General of the State of Delaware. In the latter two jurisdictions the Report would be provided in connection with other filings relating to the conversion and merger, in order to assist those regulators in their review of the proposed CareFirst transaction. As this Report addresses the situation in two states and the District of Columbia, we have not prepared it against any specific legal or regulatory requirements and CareFirst is responsible for satisfying itself that the Report complies with the requirements of any particular law in any jurisdiction in which it is submitted.

II. Company Background

The purpose of this section is to provide context on the history of CareFirst, Inc., and its non-profit operating subsidiaries.

CareFirst, Inc., is a not-for-profit holding company that operates through three wholly-owned subsidiaries: CareFirst of Maryland, Inc. (formerly Blue Cross Blue Shield of Maryland), Group Hospitalization and Medical Services, Inc. D/B/A CareFirst Blue Cross Blue Shield of the National Capital Area, and Blue Cross Blue Shield of Delaware. All three affiliates are independently licensed by the Blue Cross Blue Shield Association to market health insurance and related products throughout the Mid-Atlantic region including Maryland, Delaware, Washington, D.C. and portions of Northern Virginia.

The history of Blue Cross Blue Shield plans in Maryland begins in 1937, when fifteen community hospitals agreed to participate in the Associated Hospital Service of Baltimore and became authorized to use the Blue Cross service mark in Maryland. The focus of the Blue Cross plan was to provide pre-paid hospital services to Maryland residents during the depression and provide a steady source of income for the hospitals. In 1947, the Associated Hospital Service of Baltimore changed its name to Maryland Hospital Service in recognition of its expanded membership and hospital participation.

Maryland's Blue Shield plan was established in 1950, when Maryland Medical Service, a physician group, became incorporated and licensed to use the Blue Shield name to provide pre-paid physician services. In 1969, Maryland Hospital Service and Maryland Medical Services changed their names to Maryland Blue Cross and Maryland Blue Shield, respectively. These two Maryland Blues plans merged to form one company, Blue Cross and Blue Shield of Maryland, Inc., in 1984.

The history of Blue Cross Blue Shield in the Washington, D.C. area starts in 1942, when Group Hospitalization, Inc. a hospital association in Washington, D.C. founded in 1934, became authorized to use the Blue Cross service mark. Blue Shield was started in the area in 1952, when Medical Service of the District of Columbia became authorized to use the Blue Shield service mark. In 1985, Group Hospitalization and Medical Service of the District of Columbia merged to form Group Hospitalization and Medical Services, Inc. The trade name Blue Cross Blue Shield of the National Capital Area was adopted at the same time.

In Delaware, Group Hospital Service was incorporated in 1935 and, in 1941, became authorized to use the Blue Cross service mark. Two years later, in 1943, Group Hospital Service became authorized to offer Blue Shield coverage to Delaware residents as well. The name officially changed to Blue Cross Blue Shield of Delaware in 1965.

CareFirst, Inc., as it is known today was formed in January 1998, when Blue Cross Blue Shield of Maryland combined with Blue Cross Blue Shield of the National Capital Area. In 2000, CareFirst affiliated with Blue Cross Blue Shield of Delaware. CareFirst, Inc., is managed and controlled by its own Board of Directors and responsible for its own operations.

CareFirst's mission statement reflects its ongoing commitment to provide health care services to the Mid-Atlantic community:

> *CareFirst shall be the leading regional health care company recognized for a comprehensive portfolio of high quality innovative products and administrative services. Our purpose is to provide the best value to our customers in partnership with the health care community and in an environment which promotes respect, fairness and opportunity for our associates.*

CareFirst provides health insurance benefits and services to approximately three million members. The Company offers both managed and indemnity health care insurance products through its Blue Cross Blue Shield plans, as well as other health services products through wholly-owned subsidiaries and non-Blue affiliations (See Appendix for Chart of Subsidiaries). Approximately 70% of CareFirst's membership is enrolled in a managed care product. CareFirst's managed care product portfolio includes: Health Maintenance Organizations, Preferred Provider Organizations, and Point of Service plans (See Appendix for Product Descriptions). The Company also offers traditional indemnity products, which account for the remaining proportion of its medical membership. CareFirst's primary source of revenue comes from health care premiums received through its medical insurance products. The Company reported total revenue of $5 billion in 2000, and net income of $63.8 million.

CareFirst is headquartered in Owings Mills, Maryland. CareFirst has over 30 additional offices located in Maryland, the District of Columbia, Delaware, Virginia, and North Carolina (See Appendix for Corporate Locations). The Company employs over 6,500 employees, which it calls associates.

III. Financial Information

The purpose of this section is to provide background regarding CareFirst's financial performance over the recent past. The information for this section was obtained from publicly available sources and from CareFirst. The current year-to-date information was obtained through CareFirst. All of the financial information in this section is reported on a consolidated basis, and is in accordance with Generally Accepted Accounting Principles, i.e., GAAP.

CareFirst Year-to-Date 2001 – From January through September 2001

For the first nine months of 2001, total revenue, including premium and management services revenue, was $4.5 billion. Year-to-date, CareFirst medical expenses were 90.2% of premium revenue. Administrative expenses, as measured by administrative expenses divided by net revenue (total revenue minus investment revenue), was 9.0%.

Net income for the first nine months of 2001 was $72.7 million, resulting in a net profit margin (net income divided by total revenue) of 1.64%, an increase from the 1.23% margin reported for the same period in 2000. CareFirst management attributed the increase in net income percentage to the return on its investment, made over the last few years, in information technology (see below where IT investments contributed to impacts on net income in 1998). Reserves were $768.9 million. Reserves as a proportion of total revenues are 17.4%. Reserves are compliant with NAIC and BCBSA guidelines.

Historical Results

In March 2000, CareFirst became affiliated with the parent company of Blue Cross Blue Shield of Delaware (BCBSD). The affiliation was a "pooling of interest" transaction, and CareFirst has restated its consolidated financial statements for 1999 and 2000 as required, combining the results of CareFirst and BCBSD.

Prior financial statements were also restated to properly categorize CareFirst's Medicare and Medicaid HMO risk operations as a discontinued business segment, a decision that was made by CareFirst management in December 2000.

According to these restated financial statements, CareFirst's revenue grew at an annual rate of 12.1% over the period 1998 to 2000, reaching $5.0 billion in 2000. On average, the medical expense ratio was 89.5% of premium revenue and administrative expenses averaged 9.9% of total revenue less investment revenue.

Net income was $63.8 million in 2000, a decline of roughly sixteen percent from 1998, a trend that management primarily attributes to investments in information technology and to operating losses associated with certain public sector programs. CareFirst recorded $691.8 million in reserves in 2000. CareFirst's reserves averaged 13.1% of revenue over the 1998-2000 period.

Membership growth has driven revenue growth for CareFirst. Affiliations have been the significant source of membership growth for CareFirst. Total medical membership, including indemnity and managed care, increased by approximately 660,000 members over the period 1998 to 2000, to reach three million in 2000. This represents an annual growth rate of over 13%.

IV. Health Care Industry Context

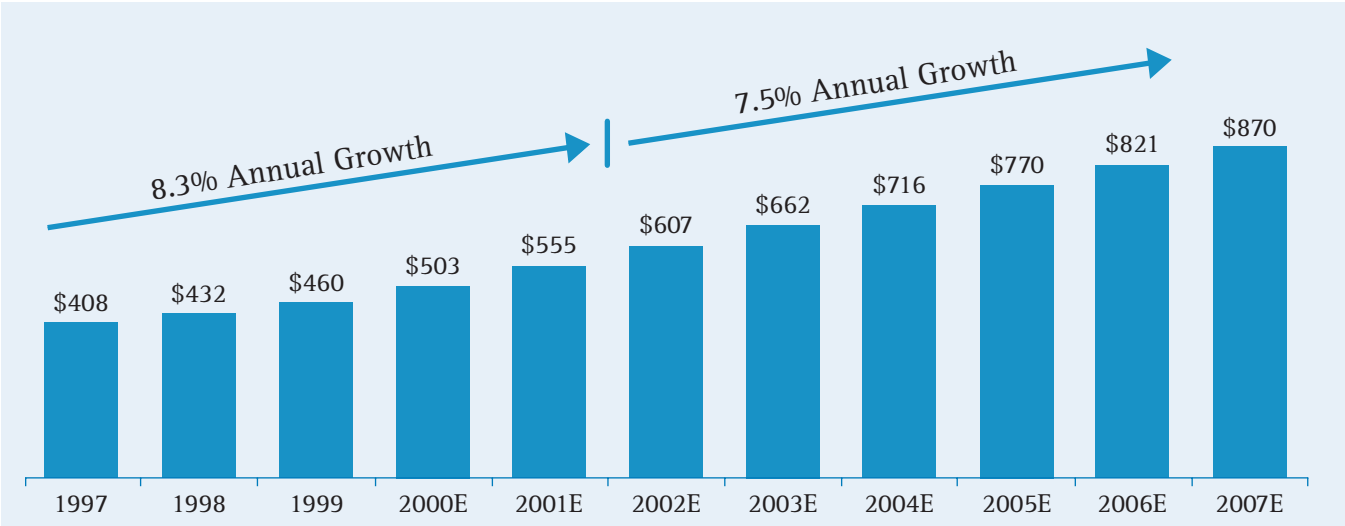
The purpose of this section is to provide context on the national and local market forces influencing health plans, and why we believe the proposed transaction is strategic to CareFirst.

The following information is excerpted from "An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response", a paper Accenture produced in November 2001 assessing CareFirst's current situation and the options CareFirst has available in order to continue serving its constituents over the long term.

Health plans are being squeezed—rising healthcare costs, state and federal mandates, changing technologies, and increasing customer expectations have narrowed health plan margins, while simultaneously accelerating investment requirements in their base business.

According to government estimates, national private healthcare costs have increased 8.3% annually, on average, over the past five years. In addition, complex regulatory mandates—most recently the Healthcare Insurance Portability and Accountability Act (HIPAA)—require significant investment by health plans.

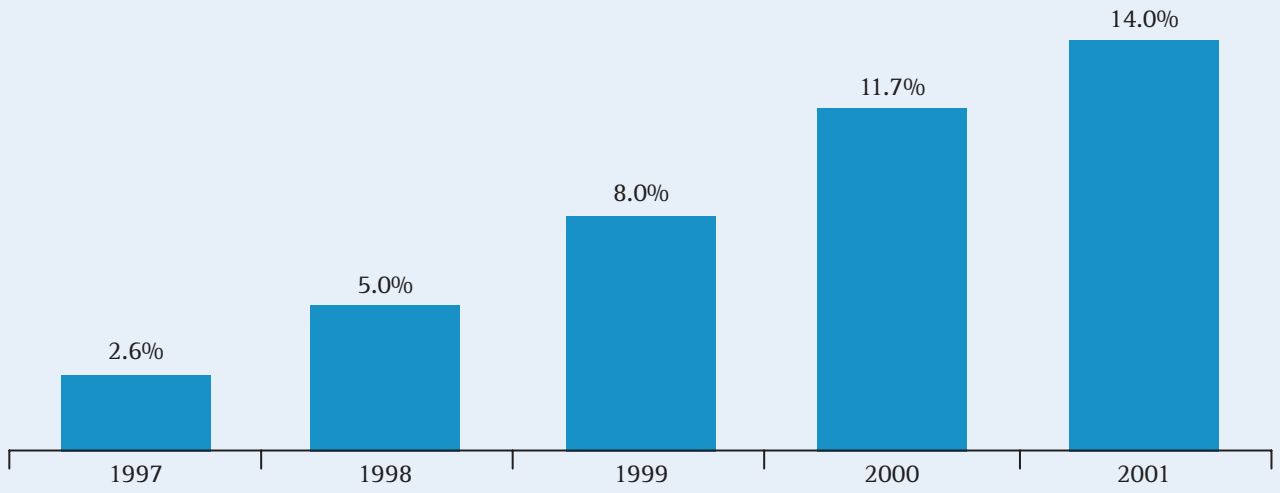
Private Health Care Expenditures
(Excluding Research and Construction, $ in Billions)



Source: Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration), *National Health Expenditure Projections, 2000-2010*, March 2001.

As a result, health plans have been forced to increase healthcare premiums significantly since 1996, with double-digit increases nationally over the past two years.

HMO/POS Rates, Percent Increase in Average Per Employee Premium
(Fully Insured Plans only)



Source: Credit Suisse First Boston, *Benefit Manager Survey*, January 30, 2001.

At the same time, health plans are trying to lessen the financial impact on customers, while enhancing the products they deliver. To mitigate rising costs, and to meet increasing consumer demands, health plans are investing in new technologies, introducing new products, and improving basic systems and processes. Furthermore, in order to improve their competitiveness, health plans have also been actively consolidating. Estimates for the cost of these investments-including HIPAA compliance—for large health plans range from $420-$640 million, and possibly more, over the next five years.

Estimated Average Health Plan Investment Needs in the Next 3–5 Years*
(For Large Health Plans with Revenues > $500 Million)

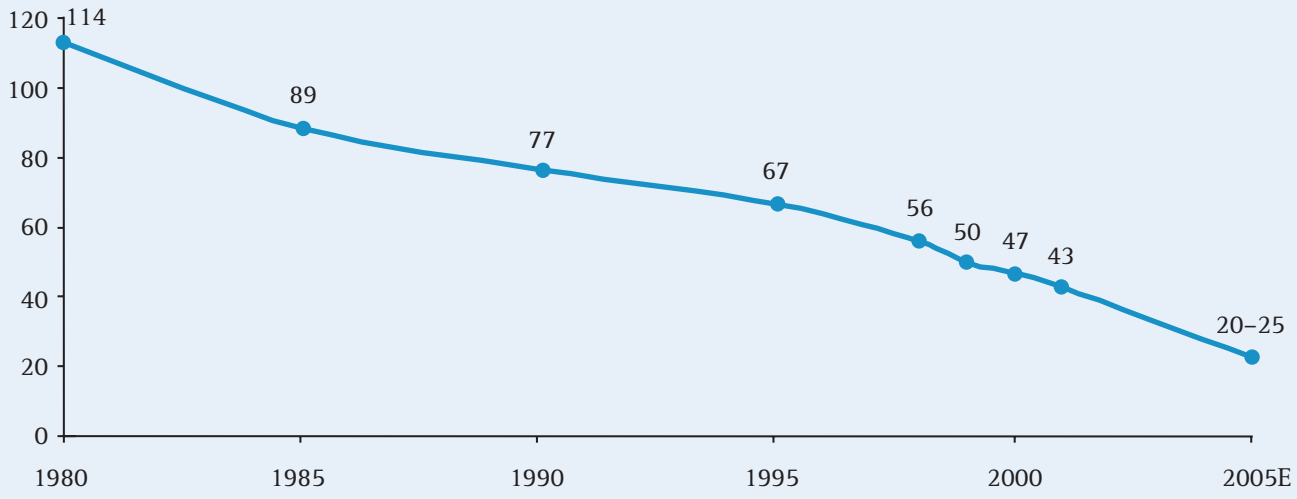
Area	Low	High
HIPAA (Health Insurance Portability and Accountability Act)	$ 30	$ 60
eCommerce	$ 10	$ 40
Consumer-focused Initiatives	$ 20	$ 40
IT Infrastructure Improvements	$ 30	$ 50
Merger and Acquisition Activity**	$330	$450
Other (e.g., merger integration expenditures, partnerships/ interconnectivity, potential future regulations, etc.)	Additional	Additional
Total Investment ($ in Millions)	**$420+**	**$640+**

* Estimates based on industry analyst projections and current market conditions; may evolve given new information over time.
** Estimates based on the average actual cash expended on mid-range health plan acquisitions since 1997, screened against available merger candidates in CareFirst's markets.
Source: Gartner Research, *2000 Payer IT Budget and Staffing Survey*, August 14, 2001; Gartner Research, *2000 IT Spending and Staffing Survey*, October 2, 2000; SEC filings; Company press releases; merger news articles; Accenture analysis, surveys and client experience.

Two popular techniques health plans are using to fight the squeeze include expansion to gain economies of scale, and accessing the public equity markets. These strategies can make operations more efficient, and better enable health plans to make the significant investments described earlier in this paper. Combined, these actions could have the potential to put health plans on a "virtuous cycle" for ongoing growth.

Increasing a health plan's member base can drive scale economies-expenditures can be spread across more members, and more funds are generated to make the investments described above. Increased scale can also help stabilize earnings, enabling a health plan to better withstand downturns in individual segments of their businesses. Many plans have gained scale by acquiring other, generally smaller, health plans. This is evidenced by multiple health plan combinations over the past 10 years, and the unprecedented reduction in the number of Blue Cross Blue Shield plans—from 114 to 43—over the past 20 years.

Number of Operational Blue Cross and/or Blue Shield Health Plans



Source: Conning & Company, *The Blue Cross and Blue Shield Plans: Past, Present and Future*, 2000; BCBSA data for years: 1980, 1985, 1990 and 2001.

When a health plan acquires another health plan that competes in the same market, there is potential for an additional advantage. Studies have shown that companies across industries perform better if they are able to maintain a strong market share relative to their competition (relative market share).

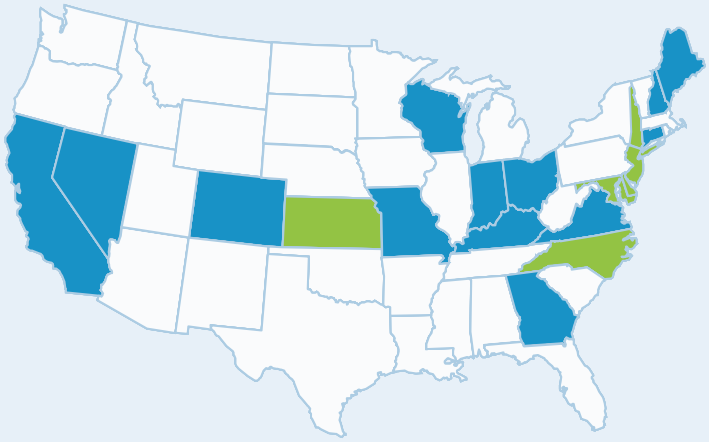
As the health insurance industry consolidates, this phenomenon also presents a threat to health plans' competitiveness. A health plan's relative market share diminishes as the health plans with which it directly competes (those in its current markets, as opposed to those in adjacent or remote markets) consolidate. If it wishes to protect its relative market share in home markets, a health plan needs to participate in the consolidation. It needs to act when local, direct competitor health plans come up for sale. Of course, doing so requires capital.

In addition to bolstering overall financial stability through economies of scale, many health plans realize the need to access capital in order to make required investments. Some are increasing access to capital through the public equity markets. A common approach is to convert to for-profit status, and then issue

shares for sale to the public. There has been a wave of such conversions, primarily among Blue Cross Blue Shield plans, with more planned. About 79 million Americans carry Blue Cross Blue Shield cards; approximately one third of those are members of Blue Cross Blue Shield plans that are either for-profit plans, or are considering a for-profit conversion.

Blue Cross Blue Shield Health Plan Conversions
(Completed and Planned Conversions as of December 2001)

	Members Carrying BCBS Cards*	% of Total BCBSA Lives
For-profit Plans	16.9M	21%
Considering or Pursuing Conversion	11.4M	14%
Total	28.3M	35%



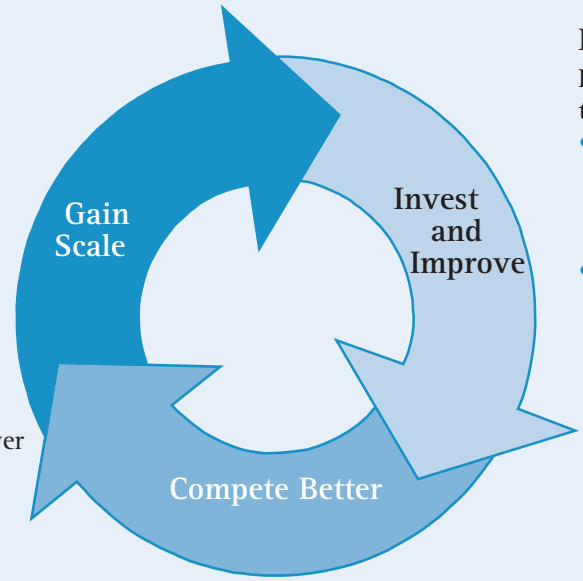
* Blue Branded Members only.
Source: Health plan public information; BCBSA enrollment data as of September 30, 2001.

The objective for taking these actions is to establish a "virtuous cycle": increased scale and access to capital drives cost reduction and investment in service improvements. These, in turn, increase a plan's attractiveness to members and employers, which in turn attracts new customers, further increasing scale, and so on.

A "Virtuous Cycle" for Health Plans

Gain Scale
Increase member base
- Increase revenues
- Position health plan for increased investment

Compete Better
Use advantages to enhance competitive position, e.g.:
- Reduced rates, or lower rate increases, due to lower operating costs
- Improved and/or differentiated services



Invest and Improve
Exploit the advantages available through increased scale
- Reduce operating costs by aggressively pursuing economies of scale – e.g., integrating core systems and operations
- Invest more in innovative and/or differentiating services and products – e.g., eCommerce, consumer-focused initiatives, improved operations

These national trends are playing out in the Mid-Atlantic region, with rising health care costs, significant investment requirements, increased scale of competitors, for-profit conversions and some health plans closing down or being acquired.

Each of these trends is affecting CareFirst specifically. For example, over the past three years, CareFirst experienced average annual health care cost increases of 7.8% in its Commercial HMO business, and 10.0% in its Maryland Small Group business. Like other health plans, CareFirst is investing to improve its service to customers, and to comply with changing regulatory requirements.

Plans in the region are participating in the industry consolidation: Coventry Health Care purchased all or parts of 11 health plans in three years; Aetna acquired U.S. Healthcare, NYLCare, and Prudential Healthcare. Several smaller plans have closed down or been acquired, including the George Washington University Health Plan, Innovation Health, and the QualChoice of Virginia Health Plan. Blue Cross and Blue Shield of Virginia, now known as Trigon, converted to for-profit status and went public in 1997. CareFirst itself represents the affiliation of Blue Cross Blue Shield plans serving Maryland, the Washington, D.C. region, and Delaware.

We believe that to maintain its competitiveness in the face of these industry pressures, CareFirst would benefit from a substantial increase in scale and capital access. One of the options available to CareFirst to do so quickly would be to combine with a large for-profit health plan.

Accenture helped CareFirst estimate that a scale of $11-$16 billion in annual revenue could greatly aid it in maintaining competitiveness over the next several years. This range was estimated based on our assessment of CareFirst's capital needs.

This scale would be very difficult for CareFirst to achieve through home-market expansion (i.e., through incremental growth). Just being able to support the strategic investments would require substantial market share expansion, adding as many as 1.4-3.1 million members to its 2000 year-end membership. Another option would be to expand beyond CareFirst's present boundaries; however, CareFirst's Blue Cross Blue Shield brand license limits CareFirst to competing with the Blue Cross Blue Shield brand in its current geographic markets. And, while less formal affiliations can provide some benefits to health plans, they generally limit the opportunities to achieve economies of scale compared with true mergers. Since CareFirst lacks sufficient capital to be an acquirer on the scale that it targets, combining with another health plan would likely be structured as a sale of CareFirst to another health plan.

Market forces appear to be driving Blue Cross and Blue Shield plans to pursue mergers and to access the public equity markets. As more and more health plans do so, plans that lack these advantages could find competing more difficult over time. Because a merger and access to public equity markets could make CareFirst a stronger company, and because CareFirst currently possesses a strong market position, the timing appears favorable for CareFirst to make such a change.

Industry analysts see the conversion of Blue Cross Blue Shield plans as not only wise, but necessary in some cases. Samuel Levitt, a leading analyst and author of a recent report by Conning & Company says:

> *"...the economic realities of healthcare leave them no choice* [but to convert to for-profit and access the public equity markets]*...we think it's not in general a very friendly environment for not-for-profits."*

A. M. Best, which analyzes the health insurance industry and rates specific organizations, published an article last year that stated:

> *"The consolidation of Blue Cross & Blue Shield plans surged during the 1990s and will continue to sweep the insurance industry well into the next century. Whether it be in response to the regulatory environment, a need for improved efficiencies or simply company survival, mergers and acquisitions have become a primary issue for most insurance companies."*
>
> Later in the article they state:
>
> *"As consolidations continue and the need for access to capital increases, the conversions to for-profit status will rise symmetrically."*

Investment bank Shattuck Hammond states in its Spring 2001 State of the HMO Industry report:

> *"In order to sustain earnings growth, national HMOs will return to the acquisition market. In addition, we believe that they will become more aggressive in their acquisition valuations."*
>
> And later:
>
> *"Rapid Blue Cross Blue Shield consolidation expected to continue...low profitability and limited access to capital have been the two primary factors driving the consolidation. The strong share price performance by the publicly-traded Blue Cross Plans as well as additional Blue Cross Blue Shield IPOs and for-profit conversions should further facilitate the consolidation through increased access to capital and diminished geopolitical obstacles."*

The timing appears favorable for CareFirst to make such a change because it is profitable and has built a strong market position. As a result, CareFirst could command an attractive price from a prospective buyer. In the past four years, the combined market share of CareFirst's three largest competitors in the region increased from 22% to 37%. Should CareFirst's competitors continue their recent improvements, CareFirst's currently strong negotiating position (by virtue of its strong market position) could be threatened.

V. Impacts on Availability, Accessibility and Affordability

To assess the potential impact of CareFirst's proposed conversion to for-profit status and merger with WellPoint on the availability, accessibility and affordability of health care services, we reviewed the merger agreement, researched similar experiences in other states (particularly WellPoint's prior actions), and queried WellPoint regarding its intentions. We assessed the potential impact of the proposed transaction against the baseline of CareFirst's business as of December 2001 where possible, the most recent time period available to us. The key steps undertaken are summarized below.

Approach to Prepare this Community Impact Analysis

1. *Identify Potential Influencers* – We identified the aspects of CareFirst's business that could influence availability, accessibility and affordability of health care services. We first considered those parts of CareFirst's business that directly touch CareFirst's members and the communities in which CareFirst operates. We also considered other parts of CareFirst's business that could influence decision-making on the member- and community-touching business components. Taken together, these influencers include:

   A. **Business Purpose and Foundations** – Would the change from non-profit to for-profit form, coupled with the creation of Public Benefit Obligation (PBO) foundations, be likely to affect availability, accessibility, and affordability?
   B. **Competition** – Would the transaction be likely to give CareFirst additional market power that could affect availability, accessibility, and affordability?
   C. **Availability and Accessibility of Doctors and Hospitals** – Would CareFirst's doctor and hospital networks or the overall supply of doctors and hospitals in CareFirst's jurisdictions be impacted?
   D. **Medical Management Policies and Practices** – Would the rules by which members access care be likely to change as a result of the transaction?
   E. **Operations** – Would service be affected?
   F. **Products** – Is it likely that products would be restricted or enhanced as a result of the transaction?
   G. **Pricing** – Is it likely that prices (health care insurance premiums) would change as a result of the transaction?
   H. **Governance** – Would the change in control impact availability, accessibility, and affordability?
   I. **Regulation** – Would CareFirst's conversion to a for-profit change regulatory oversight and thereby impact the availability, accessibility, or affordability of health care?

Medical loss ratio is sometimes used as a gross indicator of accessibility and affordability. As medical loss ratio can be influenced by many factors unrelated to accessibility and affordability, such as accounting practices and mix of business, we chose instead to examine the key drivers of medical loss ratio more directly related to accessibility and affordability. These include:

- Availability and Accessibility of Doctors and Hospitals
- Medical Management Policies and Practices
- Operations
- Pricing (health care insurance premiums)

2. *Review Proposed Transaction Specifics* – We were provided with a copy of the "Agreement and Plan of Merger By and Among WellPoint Health Networks Inc., CareFirst, and Congress Acquisition Corp." signed and dated November 20, 2001 ("Merger Agreement"). We conducted a non-legal analysis of the terms and conditions of the Merger Agreement to determine if any terms and conditions could affect any of the areas listed above for health care services in Maryland, Delaware and Washington, D.C.

3. *Analyze the Experience of Health Plans in Similar Situations* – We examined the performance of Blue Cross Blue Shield plans in two other states that have converted to for-profit status and merged. Plans examined include WellPoint's Blue Cross of California and Blue Cross Blue Shield of Georgia. We looked at these health plans to understand how a for-profit health plan is likely to behave before and after conversion, and also because they specifically involve CareFirst's proposed merger partner, WellPoint. In addition to merging with WellPoint, Blue Cross Blue Shield of Georgia is another East coast plan, like CareFirst, and similar in scale as measured by membership (approximately 2.0 million members compared to CareFirst's 2.5 million members in the Mid-Atlantic service area, and 3.12 million members overall).

4. *Apply Insights From other Situations to CareFirst's Situation* – Once we gathered insights from the similar situations, we applied them to CareFirst's situation in order to determine the potential impact on the availability, accessibility, and affordability of health care in the Mid-Atlantic region.

5. *Query WellPoint Management* – The potential impact of the transaction on the availability, accessibility, and affordability of health care depends, in part, on the policies and practices that WellPoint intends to implement post-transaction. In order to understand WellPoint's intentions in this regard, we queried WellPoint management on several specific points. Quotes from WellPoint management's responses are included in the Report below and in the Appendix.

6. *Draw Conclusions* – Finally, we drew conclusions regarding the potential impact of the merger on the availability, accessibility, and affordability of health care in the Mid-Atlantic region based on the insights from other markets, the application of the insights to CareFirst's situation, WellPoint query responses, and Accenture's understanding of the health care industry.

Findings

The purpose of this section is to provide the findings of our analysis for each business area assessed. Please see Appendix V., Section Data Sources, Assumptions and Methodologies for detail on how these findings were developed. These findings are as follows:

A. Business Purpose and Foundations –

Would the change from non-profit to for-profit form, coupled with the creation of Public Benefit Obligation (PBO) foundations, be likely to affect availability, accessibility, and affordability?

In the event CareFirst converts to a for-profit enterprise, overall availability, accessibility and affordability of health care services could improve. CareFirst's incentives would change, but Public Benefit Obligation (PBO) foundations created in each jurisdiction could make a positive and sizable impact and may assume some or all of the non-profit purposes historically associated with Blue Cross and Blue Shield plans.

Many Non-Profits are Currently Behaving Like For-Profits

The change from non-profit to for-profit corporate form will not, *per se*, change CareFirst's operating behavior. In many ways, nearly all Blue Cross Blue Shield plans today operate like for-profit health plans. Specifically, nearly all make decisions based on the business merits of any particular issue, with an eye toward making their products as attractive as possible to customers (both individuals and groups). They are forced to act in this manner in order to survive and compete effectively with for-profit health plans that

also behave this way. As a result, most Blue Cross Blue Shield plans, including CareFirst, do not play a central role today as an instrument of government or local community health policy.

For example, in most cases, non-profit health plans do not fill the role of "insurer of last resort". In a competitive market, a health plan could not survive filling that role, if its competitors did not play that role also. CareFirst is not statutorily required to be an "insurer of last resort" in Maryland. While CareFirst does participate in programs designed to address the needs of the under- and uninsured (e.g., Maryland's SAAC program), such participation is neither limited to CareFirst specifically nor to non-profits generally. Eligibility for participation in these programs is independent of an organization's form (i.e., non-profit or for-profit). Decisions regarding participation in these programs are generally made on the basis of the terms of each program and the resulting business benefit. It appears reasonable to assume that CareFirst will make decisions with regard to participation on that basis. We found no terms in the Merger Agreement that signify an intent to make decisions on any other basis.

One exception to the general trend of non-profit health plans not filling the role of "insurer of last resort" is in the District of Columbia, where a non-stock, non-profit corporation is required to offer an open enrollment program to citizens of the District[A.1]. For-profit entities are permitted to offer similar programs, but are not required to do so. CareFirst's open enrollment membership in the District has been small. As of November 1, 2001, CareFirst's Washington, D.C. plan had 678 members in an open enrollment program[A.2]. Should CareFirst convert to for-profit form, it could opt to continue to offer this open-enrollment program. A more likely outcome, however, would be that such a program would be funded through the Public Benefit Obligation Foundation formed in Washington, D.C. by the transaction (discussed later in this section). Given the small number of people using the open enrollment option, and the significant sums to be realized from this transaction, the foundation to be established could have more than sufficient resources to maintain health care availability, accessibility and affordability currently provided by CareFirst through the open enrollment mechanism.

In order to effectively compete with for-profit health plans, CareFirst's decision-making behavior must parallel that of a for-profit health plan. As a result, CareFirst's ability to serve as an instrument of health policy today is necessarily very limited. We see evidence of this in CareFirst's exit from the Medicare+Choice and Medicaid Risk programs. One reason CareFirst was unable to continue in these programs was that its network providers (i.e., physicians, hospitals and other caregivers) found participation to be economically unattractive and withdrew from CareFirst's networks[A.3]. Many health plans, including many Blue Cross Blue Shield plans, have exited these programs because the programs have led to financial losses[A.4]. The health plans exiting the programs made rational business decisions to not burden the rest of their customers with the cost of covering these money-losing programs. As a result, many Blue Cross Blue Shield plans have been less able, over time, to serve segments (e.g., the poor and the aged) that are frequently the focus of public health policy.

CareFirst's Incentives Would Change, but the Foundations May Assume Some or All Non-Profit Purposes

As a for-profit, CareFirst would continue to focus on the organization's competitive viability and financial strength, as it does today. However, CareFirst's first priority would be to earn a return for shareholders. A change in corporate form would require CareFirst to introduce more stringent financial discipline in order to ensure more predictable, stable earnings, in response to shareholder demands. Availability, accessibility, and affordability may be affected to the extent that CareFirst's minor role today in implementing

Maryland, Delaware and Washington, D.C. health policy was not replaced by the foundations to be established.

The real opportunity to affect the availability, accessibility and affordability of health care in the affected communities comes from the public benefit assets given to the various Public Benefit Organizations in the conversion. In Maryland, the Maryland Health Care Trust, with the Maryland Health Care Foundation as its trustee, is statutorily created to receive charitable assets from converting non-profit entities to be used to meet the health care needs of Marylanders[A.5]. Although Delaware and Washington, D.C. do not have similar legislation in place, historical precedent from the conversion of other Blue Cross and/or Blue Shield plans leads us to assume that Delaware and Washington, D.C. will also form foundations to receive funds from the Public Benefit Obligation coming from CareFirst's conversion[A.6]. The $1.3 billion payment for CareFirst would be divided among the three jurisdictions (Maryland, Delaware, and Washington, D.C.). It is reasonable to expect that the PBO funds in Delaware and Washington, D.C. would be used for health purposes similar to those intended in Maryland. In the absence of any definitive legislation or regulation in Delaware or Washington, D.C. on the topic, this is what we have assumed for the purposes of our Report.

Overview of Other PBO Foundations
(Foundations Created as a Result of a Conversion of a BCBS Plan)

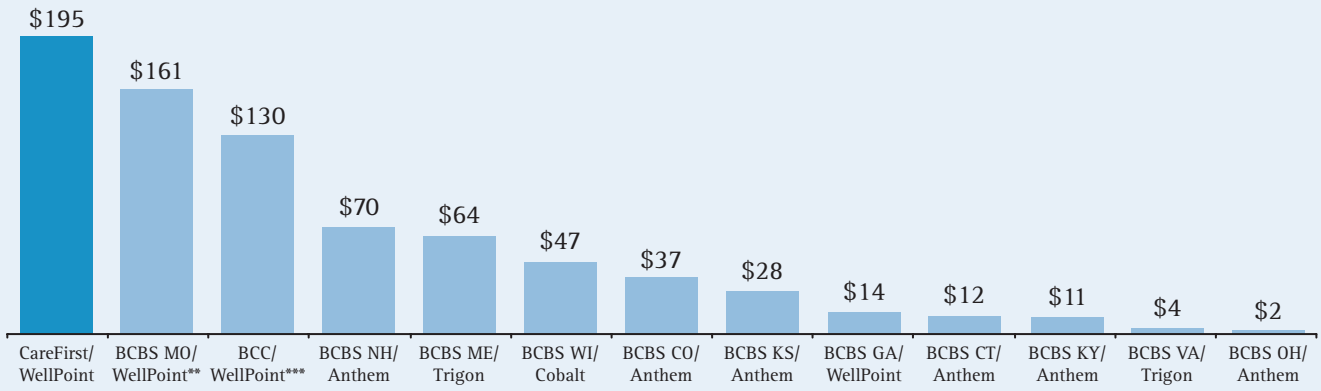
Area	Specific Focus	Foundation
Access to Health Care	• Access to health care, multicultural health and general health • Improve access for uninsured • Payment for health care services • Fund unmet health care needs • Managed care, the uninsured, health policy and quality • Health care needs of uninsured and under-insured • Serve underserved or uninsured	• The California Endowment* • Maine Health Access Foundation • Sunflower Foundation (KS) • Foundation for a Healthy Kentucky • California HealthCare Foundation • Missouri Health Foundation* • Anthem Foundation of Connecticut
Quality	• Improve health care • Improve health and reduce the burden of illness • Improve health care through capital projects, equipment and technology	• HealthCare Georgia • Endowment for Health (NH) • Caring for Colorado
Research	• Support for human research	• Commonwealth Health Research Fund (VA)
Medical Education	• Funding for state medical schools and public health	• Wisconsin United for Health*
Oral Care	• Preventive oral care and prevention of family violence	• The Anthem Foundation of Ohio

* Largest health care foundation in state.
Source: Grant Makers in Health, *A Profile of New Health Foundations*, March 2001; Health plan press releases; Community Catalyst website; Foundation Center website; Foundation websites.

The resulting PBO foundations would represent a new vehicle by which the needs of the under- and uninsured could be fulfilled. Due to the large size of the PBO foundations, $1.3 billion among Maryland, Delaware, and Washington, D.C., the foundations' ability to fulfill these purposes could well exceed CareFirst's existing ability to do so, since CareFirst's ability to be an instrument of each jurisdictions' health policy today is limited by its need to control costs in order to remain price competitive. On a per capita basis, the PBO foundations, considered together across Maryland, Delaware and Washington, D.C.

would be the largest ever created, based on the conversion of a Blues plan, in any state[A.7].

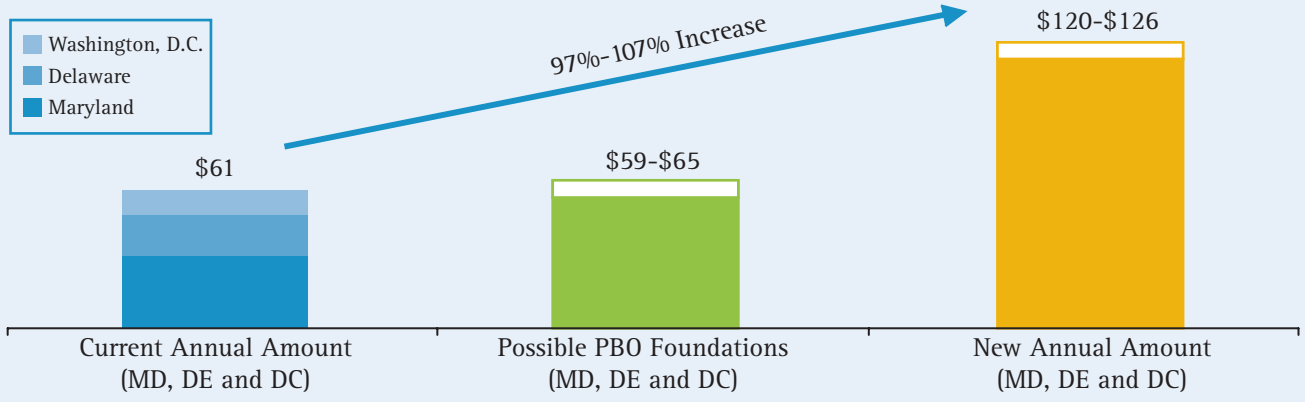
Per Capita Value of BCBS Foundations Created by For-Profit Conversion*



* Calculations are based on most recent value of foundations publicly reported. Per capita values were arrived at by dividing the current size of the foundation by the state/ jurisdiction population that the foundation services. Values of foundations created by publicly traded companies may be stock-based and will fluctuate with stock price changes.
** Value of foundation includes pending WellPoint merger.
*** BCC created two foundations which are combined for this analysis.
Source: Grant Makers in Health, *A Profile of New Health Foundations*, March 2001; Health plan press releases; Community Catalyst website; Foundation Center website; Foundation websites; U.S. Census Bureau.

On the basis of our estimates, the addition of these PBO foundations could increase the annual amount of health care grants awarded in Maryland, Delaware, and Washington, D.C. by 97%-107%[A.8, A.9, A.10].

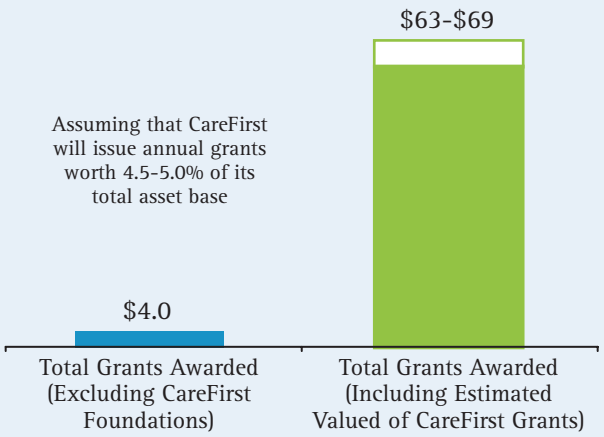
Annual Amount of Health Care Grants Awarded in MD, DE and DC*
(2000, $ in Millions)



* The search set is based on The Foundation Grants Index (circa 2000), which includes grants of $10,000 or more awarded to organizations in MD, DE or DC by a sample of 1,015 larger foundations. Foundations are located nationally. For community foundations, only discretionary grants are included. Grants to individuals are not included in the file.
Source: The Foundation Center, customized report sourced from The Foundation Grants Index.

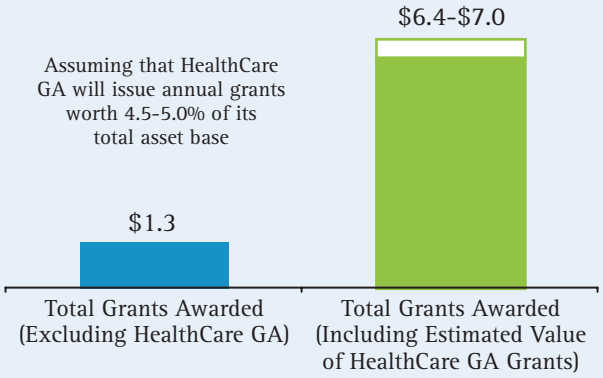
Annual Amount of Grant Awards, 2000

(Converted Foundations in MD, DE and DC only, $ in Millions)



Annual Amount of Grant Awards, 2000

(Converted Foundations in GA only, $ in Millions)



Source: Grant Makers in Health, *A Profile of New HealthCare Foundations*, March 2001, The Foundation Center by using The Foundation Directory Online.

Non-profit foundations are required to grant as much as 5% of their holdings to maintain their federal non-profit tax status, and can choose to grant more (note: some of the 5% annual payout is expected to go towards the costs of administering the foundation). For example, the California Endowment, one of the foundations created as a result of the conversion of Blue Cross of California to a for-profit business entity, awarded $197 million in grants, or approximately 5.3% of its assets, in fiscal year 2000[A.11]. These grants were awarded to support the Endowment's primary goals of Multicultural Health, Health and Well-Being and Access to Health Care. $74 million of the grant money awarded was given to CommunitiesFirst, a grant-making program designed to find community-driven solutions to persistent and emerging health challenges facing the underserved in California. Access to health care services for underserved populations has always been a primary focus of the California Endowment. Since its inception in 1996, the Endowment has awarded more than 70 grants totaling more than $60 million to support community clinics in all areas of the state.

Across all PBO foundations in CareFirst's service area, a grant rate of 4.5% to 5% of the $1.3 billion translates to $58.5 to $65.0 million spent annually on health care across the three jurisdictions. To illustrate the magnitude of this funding, if it were solely dedicated to extending Medicaid coverage to individuals that qualify for federal matching funds, the foundations alone could insure an additional 46,000 to 52,000 people in Maryland, Delaware, and Washington, D.C.[A.12] Further, the foundations may have more flexibility than CareFirst has had to direct the dollars to areas where they are needed most, because unlike CareFirst, the foundations would not be in a competitive position with other health plans.

The large collective size of the foundations is a direct result of the attractiveness of CareFirst as a business. CareFirst's current strength, combined with state budget deficits for health care programs, make the current time opportune for the proposed transaction.

Historically, For-Profits Have Continued to Contribute to Their Communities

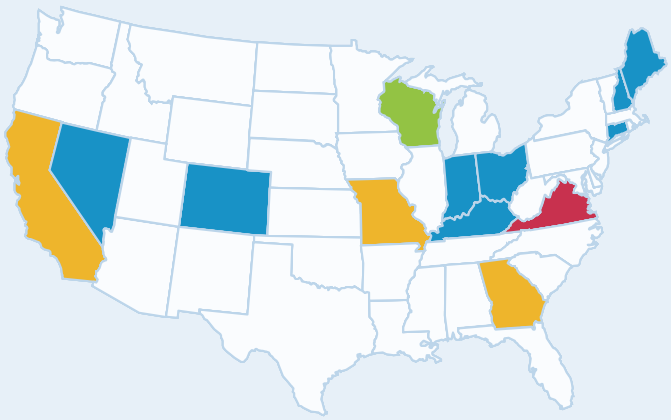
Even with a conversion to a for-profit status, CareFirst could continue to contribute to the community. WellPoint's actions in other states suggest WellPoint believes continued support for the community is positive for business. Both Blue Cross of California and Blue Cross Blue Shield of Georgia have continued contributing to the community. In each of these plans, charitable giving increased post-conversion[A.13].

The Number of Uninsured has been Decreasing

Although it may be due to a combination of factors, the overall percentage of uninsured citizens has decreased faster than the national average since 1998 in both California and Georgia where Blue conversions involving WellPoint have occurred and foundations have been established[A.14]. Although the evidence is not conclusive, it supports the theory that availability, accessibility and affordability have not been adversely impacted as a result of the conversions in California and Georgia.

Trend in Uninsured Population in States with Converted Blue Health Plan*

	CAGR** '95–'97	CAGR** '98–'00	Current Uninsured
National	+2.2%	–3.4%	14.0%
Anthem			
• Colorado	+1.0%	–1.5%	*13.3%*
• Connecticut	+16.8%	–11.7%	*8.5%*
• Indiana	–4.9%	–3.2%	*11.9%*
• Kentucky	+1.4%	–0.8%	*13.0%*
• Maine	+5.1%	+0.4%	*11.8%*
• Nevada	–3.3%	–7.9%	*15.7%*
• New Hampshire	+8.6%	–16.7%	*6.8%*
• Ohio	–1.7%	+6.1%	*10.8%*
Cobalt			
• Wisconsin	+4.7%	–16.0%	*7.4%*
Trigon			
• Virginia	–3.4%	–1.2%	*12.7%*
WellPoint			
• California	+2.2%	–6.6%	*17.9%*
• Georgia	–0.8%	–6.0%	*14.4%*
• Missouri	–7.1%	+8.3%	*10.8%*



* BCBS health plans in thirteen states converted to for-profit status prior to 2000 and are now operating as Anthem, Cobalt, Trigon and WellPoint. Although Anthem has announced its intent to acquire BCBS of Kansas, this state was excluded from our analysis because BCBS of Kansas has not yet completed its conversion. RightCHOICE/BCBS MO was placed with other WellPoint plans since WellPoint and RightCHOICE have announced intent to merge.

** The U.S. Census Bureau added a "verification" question to its 2000 survey which produced a lower and more accurate estimate of the uninsured. Only 1998 and 1999 survey results have been modified. A trend can not be drawn between uninsured rates reported prior to 1998.

Source: U.S. Census Bureau, *Current Population Reports – Health Insurance Coverage: 2000*, September 2001; U.S. Census Bureau, *Current Population Reports – Health Insurance Coverage: 1997*, September 1998.

B. Competition –

Would the transaction be likely to give CareFirst additional market power that could affect availability, accessibility, and affordability?

CareFirst will not gain additional market power of significance in this transaction.

The health care market in the Mid-Atlantic region is highly competitive. According to InterStudy, there are 54 companies that provide HMO or PPO health care services in the states of Maryland and Delaware and Washington, D.C.[B.1] In its Mid-Atlantic service area, CareFirst provides medical coverage[B.2] to 2.5 million members. WellPoint's UNICARE subsidiary will add approximately 53,000 members to CareFirst's Mid-Atlantic service area, thereby increasing CareFirst's overall market share, measured by members, by less than one percent[B.3]. Per jurisdiction, market share increases are 0.1% for Blue Cross Blue Shield of Delaware, 0.6% for Blue Cross Blue Shield of Maryland, and 1.1% for Blue Cross Blue Shield of the National Capital Area. This, combined with the fact that in the past few years the combined market share of CareFirst's three largest competitors in the region appears to be increasing (the market share of CareFirst's three largest competitors increased from 22% to 37% from 1995 to 2000[B.4]), makes it unlikely that CareFirst's market power would increase. As a result, CareFirst's ability to impact the availability, accessibility, and affordability of health care due to increased market power likely would not change to any significant degree.

C. Availability and Accessibility of Doctors and Hospitals –

Would CareFirst's doctor and hospital networks or the overall supply of doctors and hospitals in CareFirst's jurisdictions be impacted?

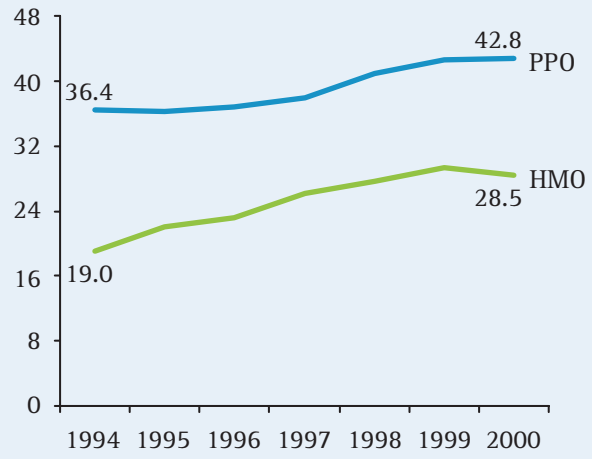
If CareFirst's conversion follows trends from other for-profit conversions, it is likely that CareFirst's networks would at least remain at their present level and could increase in overall size. WellPoint indicates that it would support expansion of CareFirst's networks. In addition, it is unlikely that the overall supply of doctors and hospitals in Maryland, Delaware, and Washington, D.C. would be affected by this transaction.

Physician and Hospital Networks at Converted Blues Plans Have Increased

The number of primary care physician, specialty physician and hospital contracts in the networks of Blue Cross of California (BCC) and Blue Cross Blue Shield of Georgia (BCBS GA) increased since each plan's conversion/merger[C.1, C.2]. The health plans appear to be *expanding* availability, not adversely affecting it. For Blue Cross Blue Shield of Georgia, the number of physician and hospital contracts has increased steadily since 1992, rising uninterrupted through the conversion and merger with WellPoint:

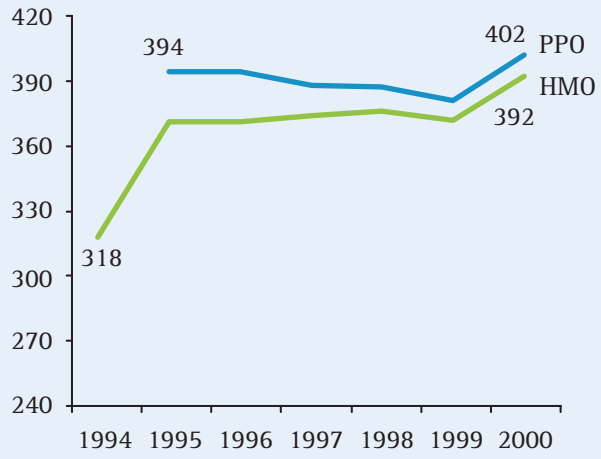
BCC – Physician Contracts*

(1994–2000, Contracts in 000's)



BCC – Hospital Contracts*

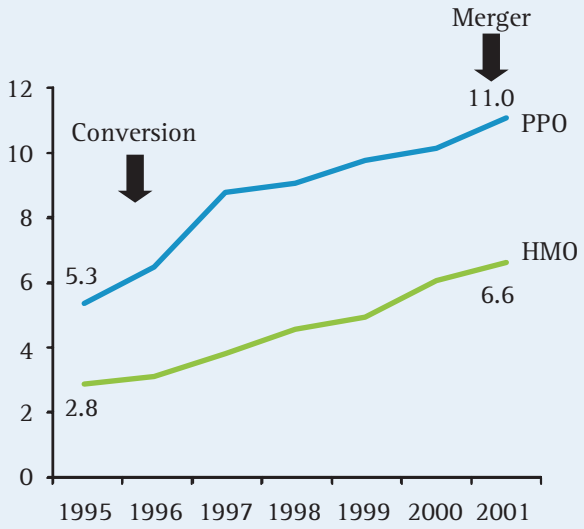
(1994–2000)



* Contract counts are as of December 31 of each year.
Source: WellPoint internal contracting data.

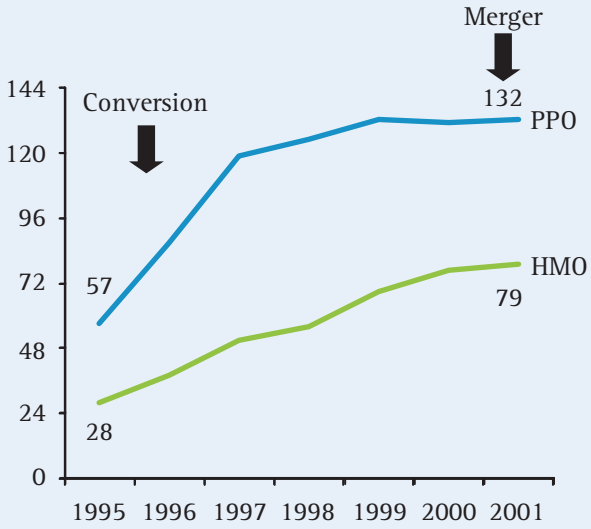
BCBS GA – Physician Contracts*

(1995–2001, Contracts in 000's)



BCBS GA – Hospital Contracts*

(1995–2001)



* Contract counts are as of March 31 of each year.
Source: BCBS GA internal contracting data.

To the extent CareFirst's experience is similar, the availability of physicians in CareFirst's service area would be positively affected.

Physician Supply Does Not Appear to be Correlated With Conversion of Blues Plans

The American Medical Association publishes annual tracking reports on physician statistics. Its latest data shows a cumulative annual growth rate in the number of physicians per 100,000 residents to be 2.3% nationally over the period 1994 - 2000[C-3]. Looking at trends for this measure across states, we see:

- For states where the local Blues plan has converted to for-profit status:
  - Five states (IN, KY, ME, NV, NH) grew at or above the 2.3% national growth
  - Four states (GA, OH, VA, WI) grew at a slightly slower pace of between 2.0% and 2.3%
  - Four states (CA, CO, CT, MO) grew at a rate of less than 2.0%
- Of the remaining thirty-seven states and Washington, D.C. where no conversions to for-profit have occurred, more than half grew at a rate of 2.3% or lower.

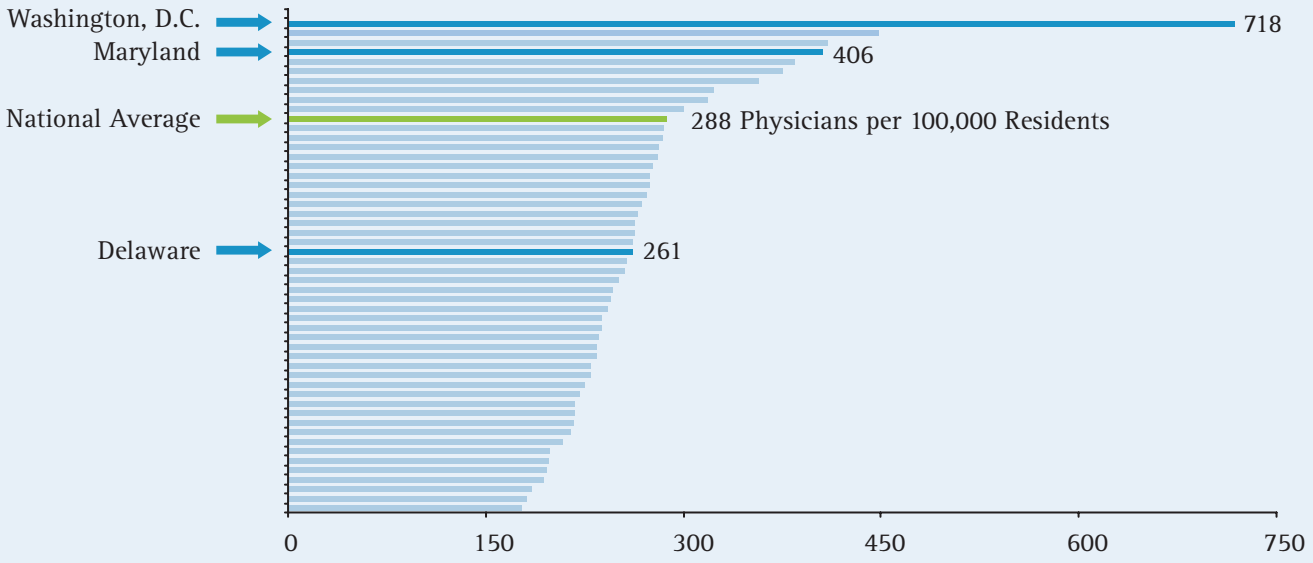
Of course, changes in either the number of physicians in each state, or the state's population would affect this measure. As a result, it is difficult to draw many firm conclusions regarding the physician supply from these statistics. We can conclude that the number of physicians nationally and in certain states is growing at a faster rate than the population. However, we can find no obvious correlation between the conversion of Blues plans and changes in physician supply.

Maryland, Delaware and Washington, D.C. Appear to Have a Good Supply of Physicians

Each of Maryland, Delaware and Washington, D.C., experienced a physician-to-population ratio growth rate of less than 2.0% from 1994 to 2000. However, the supply of physicians within Maryland and Washington, D.C. appear to be quite high relative to national averages. In 2000, the number of physicians for every 100,000 residents was 406 in Maryland and 718 in Washington, D.C. These ratios exceed the national average of 288 by approximately 40% for Maryland and 250% for Washington, D.C. Delaware, which had 261 physicians for every 100,000 residents in 2000, is 9.4% below the national average.

Physician-to-Population Ratio

(Physicians per 100,000 Residents, 2000)



Source: American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 2002 edition.

CareFirst's Contracting Strength with Physicians Unlikely to Change

Because it is unlikely that CareFirst would gain significant additional market share under the proposed transaction, CareFirst's negotiating power vis-à-vis physicians and hospitals is unlikely to change. Therefore, its ability to impose reductions in network size would not be affected.

Due to the way medical care and its financing has evolved, where a balance must be arrived at between managing affordability while supporting access to care, an economic tension has developed between doctors and health plans. The intensity of this economic tension varies from geography to geography and from situation to situation. In California, Blue Cross of California's relationship with doctors appears to have been strained. It appears that WellPoint is acting to address this. During a call with equity analysts after the announced WellPoint-RightCHOICE merger, WellPoint CEO Leonard Schaeffer specifically mentioned RightCHOICE's strong physician relationships, and stated WellPoint's intention to use RightCHOICE's physician best practices to improve physician satisfaction in other WellPoint regions[C.4]. WellPoint also hired a new Chief Medical Officer in August 2000[C.5]. Executives at Blue Cross Blue Shield of Georgia have stated to us that they believe that the merger with WellPoint has led to no substantive changes in provider contracting or network management policies or operations—despite initial community fears to the contrary.

The situational variability suggests the nature of the doctor/health plan relationship may depend more on the local practices and policies, and the local perspectives of physicians and health plans, than on health plan corporate form (i.e., non-profit or for-profit) or health plan scale. As the size and scope of a health plan's doctor and hospital networks are key customer purchase criteria, CareFirst and WellPoint have an incentive to expand their networks, not reduce them.

Hospitals are Likely to Maintain Contracting Strength in the Mid-Atlantic Region

The Maryland Health Services Cost Review Commission (HSCRC) establishes inpatient hospital payment rates paid by health plans[C.6]. This rate setting mechanism provides financial stability and leverage for the hospitals in hospital contract negotiations with health plans. Because the HSCRC establishes rates based on hospital costs, Maryland hospitals are protected against third party payors, such as CareFirst or WellPoint, using their market position to negotiate favorable contracts.

Additionally, many hospitals in CareFirst jurisdictions are members of large, multi-hospital systems and appear to have a solid negotiating position vis-à-vis the local health plans. According to the American Hospital Association, there are fifteen multi-hospital health care systems operating within Maryland, Delaware and Washington, D.C. Seven of these health care systems have national or regional operations that extend beyond CareFirst jurisdictions. The parent organizations for five of these seven systems are ranked in the top fifty of Modern Healthcare's *2001 Hospital Systems Survey*. Four of the remaining eight health care systems, which operate solely within CareFirst's Mid-Atlantic region, are ranked in the top 125. The survey, which is published annually by the established health care media publisher and which ranks multi-hospital health care systems by net patient revenue, included 227 health care systems in 2001.

Of the eight health care systems that operate solely within the Mid-Atlantic region, six operate solely in Maryland, one operates solely in Delaware and one operates in both Maryland and Washington, D.C. These eight multi-hospital health care systems, many of which also provide various outpatient care and related services, are profiled below[C.7]:

- *Adventist Healthcare*, a two-hospital health care system based in Rockville, MD
- *Christiana Care Health System*, a two-hospital health care system based in Wilmington, DE managing over 850 beds. Approximately 41,000 admissions were logged by Christiana Hospital, representing nearly 50% of Delaware's admissions in 2000. The system did not participate in Modern Healthcare's *2001 Hospital Systems Survey*.
- *Dimensions Health Corporation*, a two-hospital health care system based in Largo, MD
- *Johns Hopkins Health System*, a three-hospital system based in Baltimore managing approximately 1,650 licensed beds. Over 72,000 patients received care from Johns Hopkins hospitals in 2000, representing over 12% of total Maryland admissions. The system ranks 51st in Modern Healthcare's *2001 Hospital Systems Survey*.
- *LifeBridge Health*, a three-hospital system based in Baltimore controlling over 5% of total Maryland admissions. The system ranks 125th in Modern Healthcare's *2001 Hospital Systems Survey*.
- *MedStar Health*, a health care system operating four hospitals in Maryland and two hospitals in Washington, D.C. Collectively, the four Maryland hospitals manage nearly 1,200 licensed beds and account for 6.5% of total Maryland admissions. In Washington, D.C., the National Rehabilitation Hospital and the Washington Hospital Center manage over 900 licensed beds and control 31% of admissions. MedStar Health is based in Columbia, MD and ranks 37th in Modern Healthcare's *2001 Hospital Systems Survey*.
- *University of Maryland Medical System*, a six-hospital system based in Baltimore managing nearly 1,600 licensed beds and controlling 9.5% of total Maryland admissions. The system ranks 78th in Modern Healthcare's *2001 Hospital Systems Survey*.
- *Upper Chesapeake Health System*, a two-hospital health care system based in Fallston, MD

Data published by the American Hospital Association (AHA) for the year 2000 indicate that hospitals operating in CareFirst jurisdictions are, on average, larger and more integrated than hospitals in other states[C.8]. Mid- to large-sized hospitals comprise over 80% of hospitals based in Maryland, Delaware and Washington, D.C. while the national average is approximately 55%. Small hospitals comprise only 16% of Maryland hospitals and 9% of hospitals in Washington, D.C, but represent 46% of hospitals nationally. We know of no small hospitals operating in the state of Delaware (i.e., out of the six hospitals located in Delaware listed in the AHA data, none have 99 beds or fewer). On average, 45% of all hospitals nationally are affiliated with a health care system; however, more than 70% of hospitals in both Maryland and Washington, D.C. are in a system.

Given these facts, hospitals operating in CareFirst's jurisdictions appear to have the ability to participate fairly in contract negotiations with health plans. As neither the hospital payment rates, nor CareFirst's market power appear likely to change as a result of the proposed transaction, we would not expect the negotiating balance between hospitals and CareFirst to change. Therefore, CareFirst would not have an increased ability to adversely affect the availability, accessibility, and affordability of health care in Maryland, Delaware and Washington, D.C. based on changes in relationships with hospitals.

Blue Cross Blue Shield of Georgia's Experience Shows Growth in Hospital and Physician Networks

We note that, with Blue Cross Blue Shield of Georgia, WellPoint assigned responsibility for local physician and hospital negotiations to Blue Cross Blue Shield of Georgia. Blue Cross Blue Shield of Georgia's networks have increased in size since WellPoint acquired the Georgia plan[C.9].

D. Medical Management Policies and Practices –

Would the rules by which members access care be likely to change as a result of the transaction?

WellPoint's ability to impose significantly more restrictive medical management policies in Maryland, Delaware, and Washington, D.C. would likely be limited, because customers would choose other health plans if WellPoint were to do so. In Georgia, WellPoint has not instituted substantive changes to medical management policies.

Limited Ability to Restrict Medical Management Policies and Practices

Whenever a for-profit health plan acquires a non-profit health plan, the concern exists that the acquiring plan would restrict access to health care in order to reduce medical costs, so as to increase shareholder returns. WellPoint's ability to impose more restrictive or arbitrary medical management policies in Maryland, Delaware, and Washington, D.C. would likely be limited. This is because CareFirst's market power would not change significantly as a result of the transaction. If CareFirst were to make such changes, it would risk the loss of a substantial portion of its business to competitors whose policies remain less restrictive.

Medical policy varies from geography to geography across the U.S. The market would not accept substantive change to medical policy in the short-term. Any near term changes that were not generally accepted in the medical community would be rejected and detrimental to membership growth objectives and therefore would be counterproductive.

Blue Cross Blue Shield of Georgia Reports No Substantive Changes to Medical Policies or Practices

Blue Cross Blue Shield of Georgia executives reported to us that there have been no substantive changes to medical policy or approaches to utilization management as a result of their plan's conversion and merger with WellPoint—despite initial community fears to the contrary[D.1].

WellPoint Has Indicated an Intent Not to Restrict Access to Care

We asked WellPoint a direct question about its intentions regarding medical management policy: "Does WellPoint intend to modify medical management policies and practices [in CareFirst's service area] in a way that would adversely impact the accessibility, availability, or affordability of health care?" WellPoint responded[D.2]:

> *"No. WellPoint's goal is to offer consumers choice. WellPoint believes that one of the keys to its past and future success is its ability to introduce products that improve accessibility and affordability, especially for individuals and small employer groups. We do not intend to modify medical management policies and processes in any way that would adversely impact availability, accessibility or affordability of health care services. Of course, WellPoint complies with applicable state laws and regulations regarding medical management."*

Combined Knowledge and Systems Could Reduce Unnecessary Care Over the Longer Term

To the extent CareFirst's merger with WellPoint results in combined knowledge and systems to help doctors make better medical decisions, and those better medical decisions lead to improved overall public health

and lower long term medical costs, affordability for members may be improved. Evidence demonstrates that some medical procedures are performed inappropriately, or with incorrect frequency. For example[D.3]:

- In the Journal of the American Medical Association (JAMA), Nov. 13, 1987, p. 2533-2537, the following procedures were shown to be done inappropriately at the following rates –
  - Carotid Endarterectomy 32%
  - Coronary Angiography 17%
  - Upper GI Tract Endoscopy 17%
- In JAMA, May 12, 1993, p. 2398-2402, Hysterectomies were shown to be done inappropriately 16% of the time
- In JAMA, March 1, 1995, p. 697-701, Tympanostomies with tubes were shown to be done inappropriately 41% of the time
- Wide variation in procedure rates by geography suggest that variability is due to differences in local medical practices, not differences in patients' need for procedures. For example, the *Report on Medical Guidelines and Outcomes Research* from March 1997 states that Medicare women in the northeast are twice as likely as Medicare women in the south to undergo lumpectomy versus mastectomy.

The more information a health plan has on appropriate procedure patterns and regional practice variation, the more information it can provide doctors who can use the insight to make more informed care decisions. Studies show that when doctors are educated on medically-evidenced treatment guidelines, and those doctors in turn reference these guidelines when educating their patients regarding treatment options, some forms of inappropriate care decrease[D.3]. WellPoint's multi-region presence may benefit CareFirst in this regard, through the ability to gather broader information on an array of best practices and practice variations. Also, WellPoint has disease management programs, some of which are similar to CareFirst's existing programs, with a proven track record. When asked about this, WellPoint executives stated[D.4]:

> *"WellPoint believes that it can provide benefits to affected members through its medical management programs. Certain of WellPoint's disease management programs, such as its congestive heart failure, diabetes and asthma programs, have resulted in documented improvements in member health status and quality of life."*

E. Operations –

Will service be affected as a result of the proposed transaction?

Incentives exist to maintain long-term high service levels; however, merger integration activity has the potential to cause temporary disruption to service. Due to sharing of best practices, service has the potential to improve over the long term.

Competitive Forces Call for Maintaining High Levels of Service

CareFirst's level of customer service today, as measured in BCBSA-required quarterly performance surveys, is generally better than the median of all Blues plans nationally[E.1].

CareFirst Ranked Against All Other BCBS Plans
(Member Service "Touchpoints" only)

Member Touchpoints	CareFirst of MD	GHMSI	BCBS of DE
Enrollment Process	⬆	⬇	⬆
Proactive Member Contacts	⬆	=	⬆
Access to Providers	⬆	=	⬆
Claims Handling	⬆	=	=
Customer Service (Question or Problem Resolution)	=	=	⬇

⬆ Better than the median rating of all BCBS plans
= Equal to the median rating of all BCBS plans
⬇ Below the median rating of all BCBS plans

Source: BCBSA Survey, 12 months through second quarter, 2001.

As discussed in the **Competition** section of this Report, the Mid-Atlantic region's health insurance market is highly competitive. Thus, CareFirst and WellPoint appear to have strong incentives to maintain high levels of service, so as to retain CareFirst membership. We found no terms in the Merger Agreement that would adversely impact customer service directly.

Potential for Merger-Based Disruption; Effective Consolidation Management Can Minimize or Avoid This Risk

Mergers often involve the consolidation of systems and processes, which frequently disrupt customer service levels. This potential disruption is not unique to the transaction proposed by CareFirst and WellPoint; it is a challenge faced by every merger or acquisition. Effective management of the consolidation can minimize or avoid this potential disruption. Commenting on WellPoint's post-merger integration work with Blue Cross Blue Shield of Georgia, WellPoint's CFO David Colby stated[E.2]:

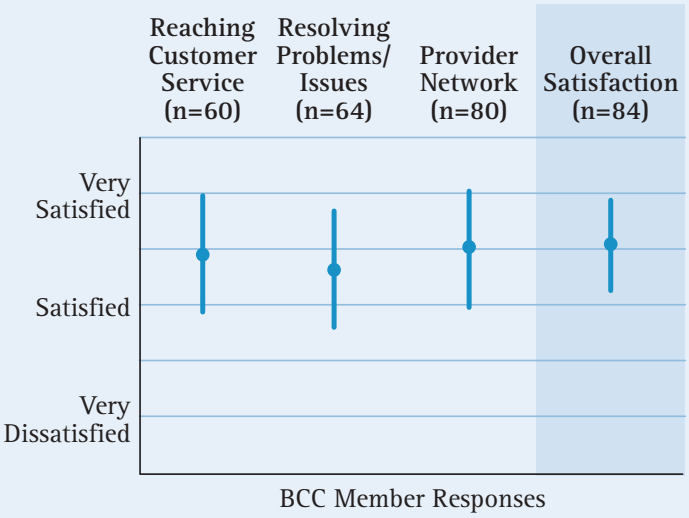
> *"We are particularly pleased with the financial performance of BCBSGA because it demonstrates our focus on successful integration planning";* and *"Our goal is to have each integration to go smoother than the one before it. This* [CareFirst] *is not a broken plan that needs heavy lifting."*

WellPoint is in the process of acquiring RightCHOICE. It appears that this acquisition will close at least one year ahead of the potential closing of the merger with CareFirst. Because the closings may be a year or more apart, the risk of these integration efforts interfering with each other is lessened.

This attention to customer service during integration appears to be a focus of WellPoint. The customers of Blue Cross of California that we spoke with through our focus groups and personal interviews were, on average, satisfied with the service they have received from their "restructured" health plan. We interviewed 85 Californians who had experience with Blue Cross of California both before and after its initial public

offering (IPO)[E.3]. On average, those people reported a slight increase in satisfaction after the IPO compared to before the IPO.

Current Level of Customer Satisfaction*



Interview Quotes

Member, BCC: I go in a lot with my kids. It's seamless to me. I pay $10 and we get out the door.

Member, BCC: I stay with Blue Cross of CA because of its good reputation, and if I have an accident, I think that they will come through.

Dave Helwig, Group President, Large Group Div, WellPoint: We have kept rate increases very steady, very predictable. As a result, retention is fantastic. We are not moving from one panic swing to another.

Broker: The conversion was transparent to us. I didn't notice any change and neither did my employers. I have noticed that things [BlueCard program] have gotten better in the last few years.

Member, BCC: Blue Cross of CA has a better network and better rates.

* For all line charts, the dot represents the average and the lines represent + or – one standard deviation.
Source: Focus group surveys and transcripts, November 2001.

Due to Sharing of Best Practices, Service May Actually Improve Over the Long Term

When health plans merge, there is an opportunity to share best practices, performance measures and standards, and to leverage common systems and infrastructure. Examples of how this can lead to improved performance include[E.4, E.5]:

- Some merged health plans have linked local customer service operations, so if one service center is overloaded, additional inquiries may be accommodated at other service centers, reducing response times.
- Introduction and/or standardization of performance scorecards, targets, and monitoring practices can increase the focus on key customer service measures such as response times, turnaround (i.e., cycle) times, productivity rates, etc.
- Elimination of out-dated, non-service oriented business processes and computer systems through the integration of "best of breed" capabilities across like products of merged plans can lead to more efficient processes and increased productivity.
- WellPoint has stated to us that they intend to use innovations in eCommerce technology in each of their plans, reducing development and deployment times, and offering another means to provide service to members, employers and physicians.

WellPoint Has a History of Proactive Investment

Looking at precedents, WellPoint's history and business incentives suggest it would choose to invest to enhance availability, accessibility, and affordability. WellPoint has a strong track record of proactive investment. Peter Kongstvedt, MD, author of The Managed Care Handbook, states[E.6]:

"They [WellPoint] *have a very seasoned, very disciplined executive team. In terms of innovation, they are certainly up in the front ranks. They don't sit back. They were one of the first out there to provide Internet capabilities to consumers."*

Also, WellPoint has invested extensively in modifying its systems platform (a complex and costly undertaking) to have common, flexible products across different states, and also to enable minimizing the costs associated with HIPAA compliance. By having common systems, WellPoint believes that investments like HIPAA remediation will be simpler and less expensive. This is an example of how CareFirst can gain the advantages of economies of scale.

F. Products –

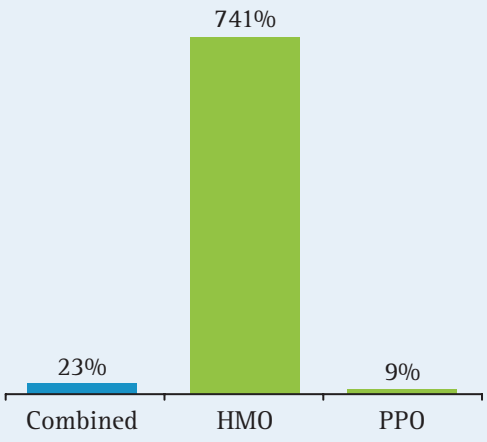
Is it likely that products would be restricted or enhanced as a result of the transaction?

Overall, availability and accessibility could improve as a result of an increase in products available.

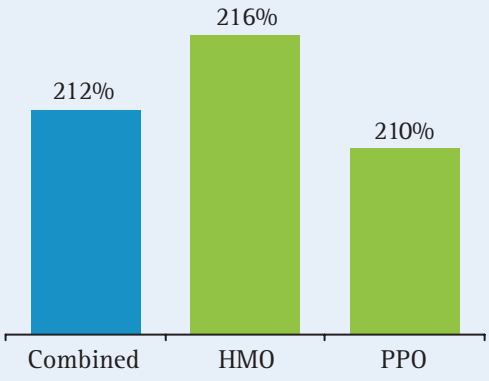
The Commercial Small Group and Individual Market Segments Appear to be Very Important to WellPoint

The histories of Blue Cross of California and Blue Cross Blue Shield of Georgia suggest that availability and accessibility could improve due to an expanded portfolio of products, especially in the individual and small group markets. WellPoint has seen its Blue Cross of California subsidiary increase its enrollment in these segments by 23% and 212% respectively since 1992[F.1].

BCC – Individual Membership Growth*
(1992–2000)



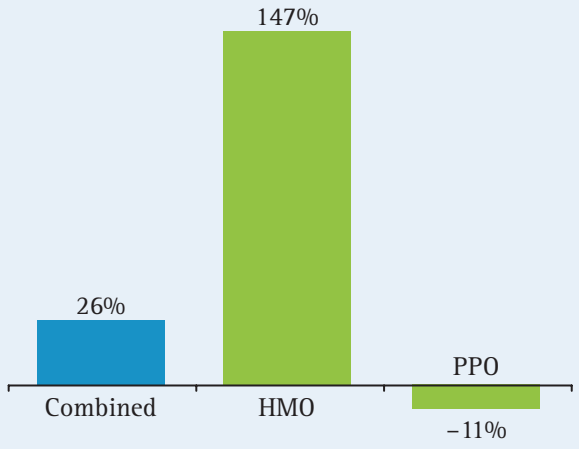
BCC – Small Group Membership Growth*
(1992–2000)



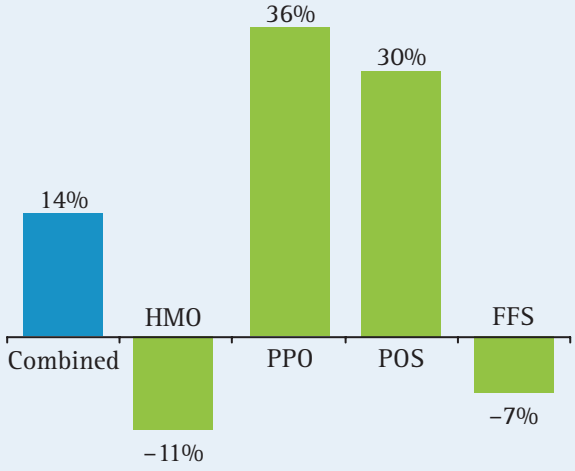
* Although PPO membership has grown slower than HMO membership, BCC had approximately seven times as many Individual PPO vs. HMO members and two times as many Small Group PPO vs. HMO members in 2000.

Source: WellPoint internal enrollment data, 2001.

BCBS GA – Individual Membership Growth
(1999–2000)



BCBS GA – Small Group Membership Growth
(1999–2000)



Source: BCBS GA internal enrollment data, 2001.

New WellPoint Products Offered to Small Employers and Individuals

Product	Introduced	Target Market	Product Description
High Deductible Plans	1997 – BCC and UNICARE*	Individual and Small Group	Members use the money deposited in a Medical Savings Account for routine medical expenses. Members protected with benefits if catastrophic medical or hospital coverage is needed.
HealthyCheck Centers	1997 – BCC 2000 – UNICARE (TX only)	Individual and Small Group	Members offered an affordable annual health care screening. Members have their deductible waived and pay a flat fee ($25 or $75) depending on the level of service desired. A summary of results is also provided to the member.
FlexScape	2000 – BCC and UNICARE	Small Group	A variety of plans that feature a range of high, medium and low benefits and price points: • **Defined Contribution:** Employer decides on a set amount to be spent on employees' health coverage per month • **Employee Elect Plus:** Employees may choose any Blue Cross Small Group Plan. Plan also gives employers the ease of administration that comes from dealing with only one health care company. • **Section 125:** Allows pretax employee contributions to cover employees' portion of their health insurance premium
PlanScape	2001 – BCC	Individual	Members offered a wide choice of plans designed to deliver benefits at a premium to match a wide range of budgets. Prices are in a high, medium and low range along with benefit packages. This program also includes **Family Elect**, a feature that allows different family members to enroll in different plans, while receiving only one premium bill per family.

* Plan offered only to UNICARE individual members.
Source: WellPoint internal data.

In order to protect and enhance its investment in CareFirst, WellPoint has an incentive to offer more, not fewer, products to the Maryland, Delaware, and Washington, D. C. markets. WellPoint's CFO, David Colby, commented on WellPoint's commitment to the small group and individual segments, stating[F.2]:

> *"We developed our FlexScape product in order to provide greater flexibility to small business owners, so they can provide a much wider variety of benefit packages to their employees. And we have over 1 million individual members, so we are committed to understanding their needs and serving them."*

Also, when commenting on growth opportunities for Blue Cross Blue Shield of Georgia, Colby stated WellPoint's commitment to the individual and small group markets in Georgia[F.3]:

> *"Obviously, one of the big opportunities in Georgia is to grow individual and small group. If we are successful at getting that up to almost 50% of the insured book, which may be tough, it'd be quite a growth."*

Finally, WellPoint CEO Leonard Schaeffer has stated, when asked about Blue Cross of California[F.4]:

> *"We've been in the ISG* [individual and small group] *business for a long time and some of you have followed us through all of that and some not. It is a very different business from large group and we have a commitment to this market segment and we have done very well in it and we think we'll continue to."*

And, regarding Blue Cross Blue Shield of Georgia, he stated[F.5]:

> *"What we would hope to do over time is to expand some of the individual and small group products to maybe address some of the issues having to do with the uninsured."*

<u>*CareFirst Has a Strong Presence in the Commercial Small Group and Individual Market Segments*</u>

The commercial small group market segment (CareFirst defines the small group segment as companies with 50 or fewer employees) and the commercial individual market segment (excluding Medicare+Choice and Medicaid) currently represent 16.4% of CareFirst's membership. Membership in each of these commercial segments has been increasing over the last few years. From 1997-2000, CareFirst's Maryland and NCA membership in the individual market segment increased 44%. Between 1999-2000 (since its merger with CareFirst) Delaware's membership in the individual market segment has increased 5.5%. In CareFirst's small group segment in NCA and Maryland, membership grew 29% between 1997-2000. In Delaware, membership increased 17.8% from 1999-2000. These statistics[F.6] suggest that the small group and individual segments of CareFirst's business are very important to the Company. Given the segments' importance to CareFirst, and WellPoint's apparent commitment to those same segments in its current markets, it is likely that continued participation in these segments would be important to CareFirst in the future.

As of December 2001, CareFirst had chosen to not participate in the Medicaid and Medicare Risk individual market segments. If WellPoint chooses to remain out of these market segments, there would be no impact on the availability, accessibility, or affordability of health care. If WellPoint chooses to enter these market segments in CareFirst's service area, customers in these market segments would have an additional option to obtain coverage (in addition to the offerings of existing participating health plans). WellPoint has one of the largest Medicaid populations in the United States, and therefore possesses experience in managing Medicaid populations should it decide to enter the markets in CareFirst's jurisdictions.

G. Pricing -

Is it likely that prices (health care insurance premiums) would change as a result of the transaction?

Health insurance premiums will continue to rise with medical cost inflation as they have in the past. We believe that premiums for most CareFirst customers will not change substantially beyond normal inflation as a result of this transaction. CareFirst customers in Maryland, Delaware, and possibly Washington, D.C. insured indemnity and PPO product lines would incur the additional cost of premium taxes as a result of the conversion; this revenue would benefit the states.

WellPoint has an incentive to achieve a return on its investment in CareFirst. Assuming its targets are similar to those of other publicly-traded health companies, WellPoint's return and growth target could likely be achieved through cost savings and new product sales without raising prices beyond levels they would be otherwise. Furthermore, WellPoint's ability to raise prices in Maryland, Delaware, and Washington, D.C. would be limited by competitive market pressures.

Premiums Will Continue to Rise With Medical Cost Inflation Regardless of Transaction

As discussed earlier in this Report, health care insurance premiums have risen in reaction to medical cost inflation (medical cost components include pharmaceutical, hospital, physician, nursing home and other costs, as described in the Centers for Medicare and Medicaid Services' *National Health Expenditure Projections 2000 - 2010*, March 2001). They will continue to do so regardless of CareFirst's proposed for-profit conversion and merger with WellPoint. The potential pricing impacts described in this section (section G) pertain only to the incremental change in health care insurance premiums from this ever-increasing base.

Some Members Will Incur Premium Taxes

As a result of its conversion from a non-profit to a for-profit corporation, CareFirst will incur the additional cost of premium taxes on its insured indemnity and PPO business in Maryland and Delaware. In Washington, D.C., additional taxes would be incurred if CareFirst elects to exit the open enrollment program after for-profit conversion. If CareFirst remains in the Washington, D.C. open enrollment program and converts to a for-profit corporation, the premium impact on members due to taxes is unclear.

CareFirst and WellPoint state that the new premium taxes incurred in Maryland, Delaware, and Washington, D.C. would likely be passed on in full to the affected customers. Using this assumption, approximately 510,000 CareFirst members in Maryland and Delaware would experience a premium increase of 2%[G.1], averaging approximately $4.34 per member per month as a result of the transaction[G.2]. If CareFirst elects to exit the open enrollment program in Washington, D.C., approximately 114,000 members would

experience a premium increase of 0.7%, averaging $1.82 per member per month as a result of the transaction. For members in many employer-sponsored health plans, a significant portion of these increases would be borne by the employer.

New Tax Revenue Benefits Maryland and Delaware

The additional funds collected would go directly to Maryland and Delaware. CareFirst estimates $29.0 million in new premium taxes would go to the states[G.2]. So while the affordability of health care for some customers would be adversely affected as a result of paying premium taxes, the proceeds would go directly to the states for use as they deem appropriate. The governments in Maryland and Delaware determine where and how the $29.0 million is spent, as well as the premium tax rates, so they control the eventual impact on the overall affordability of health care.

Earnings Growth Similar to Other Publicly Traded Health Companies Appears Achievable

Whenever a for-profit health plan acquires a non-profit health plan, the concern exists that the acquiring plan would raise prices in order to increase shareholder returns. As a publicly traded for-profit, WellPoint needs to generate a return on its $1.3 billion investment in CareFirst. Based on comments from WellPoint, it appears that WellPoint's plan to achieve a return on its investment focuses on cost savings and new product sales, not raising prices. WellPoint's return on its investment would come from the earnings generated by CareFirst, and any synergies it could capture in addition to those. During a conference call with equity analysts to discuss the announced WellPoint-CareFirst Merger Agreement, WellPoint CFO David Colby stated[G.3]:

> *"We believe we will achieve revenue synergies of $30 million within 3 years. The revenue synergies will come from new products that we offer, conversion of CareFirst to our pharmacy benefit management company, and the potential for life and dental penetration in CareFirst's markets. On the cost side, the cost synergies would be reduced duplicate overhead costs, plus lower administrative costs due to economies of scale in the region."*

We queried WellPoint about its pricing intentions, asking the direct question "Does WellPoint plan to raise prices in CareFirst's jurisdictions?" to which WellPoint responded[G.4]:

> *"There will be no increase in premium rates as a result of this merger. Any increases or decreases in premium rates following the merger will be made in the same manner as those occurring prior to the merger—they will be made by local market managers after taking into account all relevant factors including increases in health care costs."*

Investors expect any publicly traded company, including publicly traded health plans, to meet certain expectations for earnings growth. WellPoint investors also have growth expectations for the company. Historically, WellPoint has achieved earnings growth through a variety of means, including revenue growth, administrative cost reduction, investment earnings, and other means. Based on its historical performance, it appears WellPoint's revenue growth has contributed about two-thirds of total growth, with the remaining growth coming from other factors.

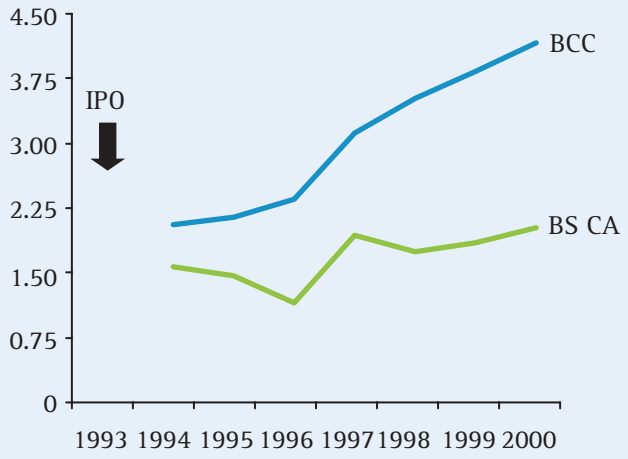
Health industry financial analysts project the the group of publicly-traded health companies will experience an earnings growth rate of approximately 15% annually over the next five years (First Call's Health Industry earnings growth projected for the next five years is 15.89% annually; Bloomberg's five-year earnings projection for the "MED-HMO" industry is 14.8% annually[G.5]). We assume WellPoint shareholders would hold similar expectations for WellPoint's earnings growth. If WellPoint were to achieve 15% annual earnings growth, and revenue growth were to comprise two thirds of earnings growth, annual revenue growth would have to be 10%. With private heath care inflation averaging 8.3% annually over the last five years (see Section IV, Health Care Industry Context), the large majority of the 10% revenue increase may be met merely through premium increases due to medical cost inflation. Other revenue growth could come through new customer sales, new products, or future acquisitions. The remaining earnings growth could be achieved through modest reductions in administrative costs, improvements in investment earnings and/or improvements in business mix, without resorting to additional price increases. CareFirst's financial plan for 2002-2005 describes an approach to achieve 15% annual earnings growth without price increases beyond those driven by medical cost inflation. So, it appears WellPoint could reasonably meet the expectations of shareholders without raising premiums in CareFirst's market area beyond what they would have been otherwise.

The Competitive Market Will Help Control Prices

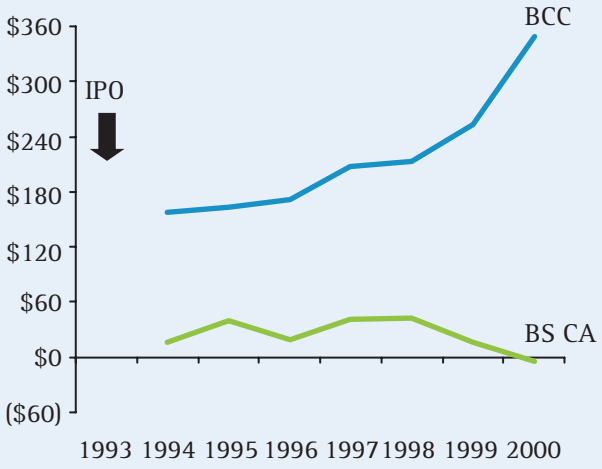
Furthermore, CareFirst's market power will not change significantly as a result of the transaction. As a result, CareFirst's ability to raise prices significantly above competitors' prices without affecting market share would be limited. If CareFirst were to attempt such a move, it would likely cause CareFirst to lose a significant amount of business.

If WellPoint's history with its Blue Cross of California plan serves as a guide, we would expect CareFirst to strive to make its products *more*, not less, competitive in Maryland, Delaware, and Washington, D.C. after a merger with WellPoint. If it follows the same strategy as it did with Blue Cross of California, WellPoint is likely to pursue shareholder value by winning more customers (i.e., growing market share). It can only do so if customers perceive they are receiving good value (benefit minus price) from WellPoint products. Since WellPoint's initial public offering, its membership in California has nearly doubled[G.6]. This suggests people in California are purchasing more of WellPoint's products because they find them a better value than competitors' products.

BCC – Total Membership
(in Millions)



BCC – Net Income
($ in Millions)



Source: InterStudy, The National HMO Financial Database, 1994-2000, data pulled from state Department of Insurance filings; Blue Cross of California membership figures include 125,000 members acquired through Omni Health Plan acquisition.

Access to Public Equity Capital Eases Reliance on Premiums as a Financing Mechanism

Access to the public equity markets through WellPoint would provide CareFirst another source of capital to finance investments, enabling it to rely less on customer revenue to finance investments. Today, CareFirst finances nearly all of its investments through its earnings. As earnings are driven, in large part, by revenues, CareFirst's ability to invest depends heavily on the premiums it collects from customers. If CareFirst has a large investment need, it must either earn more premiums or reduce its costs to fund the investment. If it is unable to do either sufficiently, it may be forced to forego the investment. If CareFirst converts to a for-profit company and merges with WellPoint, it would have access to equity capital. By virtue of being a public company, it would also have greater access to a variety of debt capital markets. This enhanced capital access would not only allow CareFirst to be less dependent on premium pricing to fund investments, it would also provide CareFirst more flexibility to invest at the time it needs to invest.

H. Governance –

Would the change in control impact availability, accessibility, and affordability?

Because of the proposed change in ownership, WellPoint would control CareFirst activity. As such, WellPoint would have the ability to affect availability, accessibility and affordability. WellPoint's long-term incentive is to favorably impact these dimensions of health care. Furthermore, the terms of the Merger Agreement call for local decision making in several significant respects.

WellPoint Will Control CareFirst Activity; Long-term Incentive Appears to Be to Respond to Customer Needs

Obviously, as a result of the transaction, WellPoint would control CareFirst. Therefore, it will have an ability to impact availability, accessibility and affordability. A number of factors provide WellPoint with the long-term incentives to favorably impact availability, accessibility, and affordability in order to

positively respond to customer needs, including:

- **Competitive Forces** – As discussed in the **Competition** section of this document, CareFirst's market power does not appear to change significantly as a result of the transaction. Therefore WellPoint's ability to impose more restrictive policies or practices in CareFirst's jurisdictions would likely be limited, because to make such changes would risk the loss of a substantial portion of its business to competitors whose policies remain less restrictive. Increasing responsiveness to customer needs would be a more appropriate approach to those competitive pressures.
- **Growth Targets** – As discussed in the **Pricing** section, WellPoint has revenue growth goals, and the objective to meet a portion of those goals through membership growth. In order to attract new members, WellPoint would need to work with CareFirst to provide a more attractive and/or differentiated set of products and services in order to win more customers. As discussed in the **Products** and **Operations** sections, WellPoint has a history of innovative product development and proactive investment in service operations, which appear to have the long term effect of positively impacting availability, accessibility and affordability.
- **Terms of the Agreement** – No terms of the Merger Agreement indicate an intent on the part of WellPoint to negatively impact availability, accessibility or affordability.

Many Decisions Will be Made Locally

The terms of the Merger Agreement explicitly call for continued local governance in many important respects, including:

- **A transition team well represented by local CareFirst executives** – "The Parties shall form a transition team (the "Transition Team") consisting of an equal number of representatives of CareFirst and Purchaser. The Transition Team shall be responsible for facilitating a transition and integration planning process to facilitate the combination of the operations of CareFirst and Purchaser." (Section 6.2 (b))
- **A CareFirst representative on WellPoint's Board of Directors, pending approval** – "Effective as of Closing, Purchaser (after consultation with CareFirst) will nominate for election one non-employee member of the existing Board of Directors of CareFirst to serve on Purchaser's Board of Directors and will use Best Efforts to have the CareFirst designee appointed or elected to Purchaser's Board of Directors." (Section 6.13 (a))
- **CareFirst's Chief Executive Officer will continue to be in charge of operations in CareFirst jurisdictions** – "At the Effective Time, the Chief Executive Officer of CareFirst shall be named the President of Purchaser's Southeast Business Region with overall responsibility for all of the business operations of the Surviving Corporation [i.e., the merged CareFirst-WellPoint subsidiary corporation] and the CareFirst Subsidiaries in the Southeast Business Region." (Section 6.13 (b))
- **CareFirst's senior executives will continue to hold significant responsibility in the merged corporation** – "Other senior executives of CareFirst will be assigned significant responsibilities with respect to the business of the Surviving Corporation." (Section 6.13 (b))
- **Local advisory boards will be in place to guide local relationships** – "An advisory board will be formed for each of the BCBS-NCA [National Capital Area, i.e., Washington, D.C.], BCBS-MD and BCBSD...Each advisory board will provide guidance to its respective company regarding the company's relationship with subscribers (both group and non-group), physicians and hospitals, and the general public. Each director appointed to an advisory board shall serve for a term of two years from the Closing on the same terms and conditions currently applicable to such person's service on the Board of Directors of CareFirst, BCBS-NCA, BCBS-MD or BCBSD as of the date hereof." (Section 6.13 (c))

- **Local headquarters will not be moved** – "The headquarters of BCBSD, BCBS-NCA and BCBS-MD shall be located in the State of Delaware, the District of Columbia and State of Maryland, respectively." (Section 2.6)

WellPoint's Stated Management Philosophy and Merger History Appear to Support Local Decision-Making
WellPoint CEO Leonard Schaeffer has repeatedly stated, "health care is locally delivered and locally consumed[H.1]." This philosophy has been put into action with WellPoint's merger with Blue Cross Blue Shield of Georgia[H.2], where:

- Former BCBS of Georgia managers occupy 12 of the top 14 officer positions in the WellPoint Georgia subsidiary
- Warren Y. Jobe, a former member of the Blue Cross Blue Shield of Georgia Board and retired Senior Executive of the Atlanta based Southern Company, is also now a member of WellPoint's Board of Directors
- Physician, hospital, and consumer advisory boards are new innovations brought to Blue Cross Blue Shield of Georgia by WellPoint. Members of these boards are from local communities, hospitals, physician groups
- Corporate headquarters remain in Atlanta and the plan's Service Center remains in Columbus, Georgia

Local Regulations Will Remain in Effect
CareFirst will remain subject to local laws and health/insurance regulation governing for-profit health plans. Decisions made in California regarding CareFirst's business activities must comply with these laws and regulations.

I. Regulation –

Would CareFirst's conversion to a for-profit change regulatory oversight and thereby impact the availability, accessibility, or affordability of health care?

As a result of a conversion, regulatory powers would change in Washington, D.C. over the requirement to offer open enrollment. However the resulting Washington, D.C. foundation could assume the role of fulfilling the needs of those needing open enrollment.

As a result of a conversion, regulatory powers would change in Maryland over the management of CareFirst's reserves. However, CareFirst's financial strength and its ability to efficiently manage reserves could significantly improve as a result of a merger with WellPoint.

CareFirst's conversion to a for-profit does not appear to result in a loss or diminution of state regulatory oversight in Delaware.

Changes in Washington, D.C. Over Open Enrollment; Likely to be Covered by New Foundation
Regulations in Washington, D.C., require a non-stock, non-profit corporation (defined in 35-3501(2) of the District of Columbia Official Code, 2001 Edition) to offer an open enrollment program[I.1] (31-3514(a) of the same code states: "A corporation issued a certificate of authority under this chapter shall make available to

citizens of the District of Columbia an open enrollment program under the terms set forth in this section"). For-profit health plans are permitted to offer similar programs, but are not required to do so. As discussed in the **Business Purpose and Foundations** section of this Report, decisions regarding participation in these types of programs are generally made on the basis of the terms of each program and the resulting business benefit. It appears reasonable to assume that CareFirst will make decisions regarding participation on that basis. There do not appear to be any terms in the Merger Agreement that signify an intent to make decisions on any other basis. Most health plans, whether for-profit or non-profit, would not choose to offer open enrollment without compensation for doing so. We expect the resulting for-profit CareFirst entity in Washington, D.C. to behave likewise. However, similar to the Maryland foundation, we would expect the needs of those citizens utilizing an open enrollment program to be served by the Washington, D.C. foundation that would be established (please see the section in this Report on **Business Purpose and Foundations**).

Changes in Maryland Over Reserves

Regulators in Maryland hold the power to exercise a greater degree of control over the reserves of non-profit health plans than the reserves of for-profit health plans[I.2] ((§ 14-117) (e) (2) "After the Commissioner has determined the surplus of a corporation authorized under this subtitle to be excessive, the Commissioner: (i) may order the corporation to submit a plan for distribution of the excess in a fair and equitable manner"). Such distributions improve the affordability of health coverage for individuals over a short period of time. However, this power is seldom used by regulators, and was last invoked over 15 years ago[I.3]. Furthermore, it is unclear that if it is used, it actually improves affordability over the long term, since a forced distribution may hamper a health plan's ability to make investments that potentially improve long-term affordability.

CareFirst would remain subject to local laws and health/insurance regulations governing for-profit health plans. One purpose of these laws and regulations is to protect the affordability, accessibility, and availability of health care to Maryland's citizens. These laws and regulations will not change as a result of the proposed transaction.

CareFirst's Overall Reserves Meet State and BCBSA Minimums

Financial strength is required to maintain CareFirst's ability to sustain adequate levels of availability, accessibility, and affordability of health care to its members. State laws and BCBSA regulations ensure that CareFirst's capital reserves are at a level that maintains financial adequacy. The proposed transaction could improve CareFirst's financial strength and provide an opportunity to use capital more efficiently.

- Compared with other Blue Cross Blue Shield plans, CareFirst ranks near the middle in terms of its reserve level[I.4].
- CareFirst's current reserve exceeds state minimum levels. Maryland, Delaware and Washington, D.C. have adopted the National Association of Insurance Commissioners (NAIC) guideline that health plans maintain reserves of at least 200% of Risk Based Capital (RBC). CareFirst's combined reserve (for all three jurisdictions) as of September 30, 2001 is 622% of RBC[I.5], above the state minimums.
- CareFirst must also meet BCBSA reserve requirements in order to maintain its Blue Cross Blue Shield service mark license (its Blue Cross Blue Shield trademark). We understand that BCBSA reserve requirements are more stringent than the NAIC guideline. These requirements are proprietary and confidential, so BCBSA does not disclose them. If a Blue Cross and/or Blue Shield plan falls below a specific multiple of RBC, it is put on a monitoring program by BCBSA. If it falls further below that

multiple of RBC, it is considered at-risk by BCBSA and is subject to additional restrictions and interventions. BCBSA looks at CareFirst's RBC overall, not by jurisdiction. As the combined CareFirst entity is currently at 622% of RBC, and above the monitoring or at-risk levels, it is not subject to BCBSA monitoring.

The Proposed Merger Could Help CareFirst Manage Capital More Efficiently

Affordability of health care could be enhanced to the degree CareFirst, post transaction, could more efficiently manage the capital required for reserves, and reflect the efficiencies gained in its product pricing. Currently, CareFirst is restricted in its ability to move reserves between jurisdictions. The proposed transaction may provide an opportunity for CareFirst and regulators to structure reserve policies that might provide CareFirst additional flexibility to economically manage its capital. More efficient management of capital can favorably impact affordability by reducing CareFirst's costs.

Should the merger with WellPoint be approved, CareFirst would have access to the public equity markets as a source of capital. As a result, CareFirst would not have to rely solely on its earnings to generate capital for reserves. CareFirst would also be part of a much larger entity. The earnings, assets, and investments of the broader WellPoint entity could be used to improve availability, accessibility, and affordability to customers in Maryland, Delaware, and Washington, D.C. Large multi-region health plans such as WellPoint, by virtue of their size and geographic diversification, are also better able to withstand regional market downturns. CareFirst's choice of WellPoint as a merger partner brings it the benefit of becoming part of the one of the largest health plans in the United States.

Conclusions

In any transaction like CareFirst's proposed for-profit conversion and merger with WellPoint, there are risks to health care availability, accessibility, and affordability. These include the risk that premiums increase beyond medical inflation, care becomes more difficult to access, management decisions are not as responsive to local community needs, market segment focus narrows, service gets temporarily disrupted, or other scenarios occur. However, transactions like these also hold significant potential to improve health care availability, accessibility, and affordability. We conclude from our analysis that the proposed transaction has a stronger potential to positively impact the availability, accessibility, and affordability of health care in Maryland, Delaware and Washington, D.C. We conclude this for the following reasons:

1. **The New Foundations Could Have a Significant Positive Impact on All Citizens in the Region.** The foundations to be created could assume some or all of the non-profit purposes historically associated with Blue Cross Blue Shield Plans, and would likely possess the economic ability to make a significant positive impact in that role serving all Maryland, Delaware and Washington, D.C. citizens, including those citizens perceived to be underserved today. The $1.3 billion proceeds would provide the largest per capita proceeds of any Blue Cross Blue Shield conversion. We presume the incentives for the foundation(s) would be consistent with improving the availability, accessibility, and affordability of care for all Maryland, Delaware, and Washington, D.C. citizens.

2. **CareFirst's Ability and Motivation to Serve its Members Could Well be Enhanced.** The transaction may well enhance CareFirst's ability to improve availability, accessibility, and affordability of health care to the members it serves. By virtue of the transaction, CareFirst could: gain access to new systems and technologies, achieve scale economies, benefit from the management expertise and best practices of WellPoint, expand its product portfolio using WellPoint-developed products, strengthen its financial position by association with a larger, more geographically diverse entity (WellPoint), and gain better access to capital. Furthermore, the merged CareFirst-WellPoint health plan appears as if it would have the business incentive to favorably impact availability, accessibility, and affordability of care for the members it serves, in order to attract and retain customers. Its incentive would be to protect and grow its current membership base.

3. **The Timing Appears Opportune to Benefit Both CareFirst and the Prospective Foundations.** Given national and local trends regarding increased costs, required investments and competitive pressures, now appears to be a good time for CareFirst to continue to pursue increased scale through merging with another plan and accessing public equity markets. This approach could enhance CareFirst's ability to thrive so it can continue to serve and satisfy its constituents' needs over the longer term. By pursuing the transaction while it is strong, CareFirst can command an attractive price, thereby providing attractive value for the foundations that could serve the health care needs of all citizens in the region.

4. **WellPoint's Track Record and Intent Appear Aligned With Improving Health Care Availability, Accessibility and Affordability.** WellPoint appears to have the intention, as evidenced by proposed terms of the transaction, query responses from WellPoint management, and actions in Georgia and California, to positively impact the availability, accessibility, and affordability of health care for its members.

5. **Market Discipline Will Encourage Ongoing Service to the Market.** Competitive market forces will continue to encourage CareFirst to enhance the availability, accessibility, and affordability of health care for its members. Should CareFirst allow its products to become less competitive on any of the three factors, it would be punished through the loss of customers.

We believe that we have taken a prudent approach in examining the question of impact on the availability, accessibility, and affordability of health care in Maryland, Delaware, and Washington, D.C. Our Report is based on our identification and analysis of potential issues, analysis of the terms of the merger agreement, evaluation of historical precedence involving WellPoint in previous transactions of a similar nature, and queries of WellPoint. Based on our approach, and the information available to us, we believe our conclusions are reasonable and supportable with the facts available to us. It is impossible, however, to predict with complete accuracy the future result of any transaction such as the one proposed. The actual result may differ from our conclusions, depending upon unforeseen factors. However, based on our analysis, we believe it is reasonable to conclude that the availability, accessibility, and affordability of health care in Maryland, Delaware, and Washington, D.C. has a strong potential to be positively impacted by the proposed transaction.